DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2021

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Message from the Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Fiscal Year (FY) 2021 performance budget. In FY 2021, over 145 million Americans will rely on the programs CMS administers including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Exchanges. To accomplish this mission, we must empower patients to work with their doctors and make healthcare decisions that are best for them. Our beneficiaries and consumers need to be equipped with meaningful information about quality and costs in order to be active health care consumers.

CMS' vision for the year ahead is progressively focused on a more competitive American health care system that delivers affordable, high quality care, at a sustainable cost, with less burdensome regulations. Supporting this vision, CMS has established an agency-wide objective to 'Improve the nation's health and quality of life'.

This CMS agency-wide objective will be achieved through our continued focus on advancing our 16 Strategic Initiatives:

1. Strengthening Medicare
2. Transforming Medicaid
3. Marketplace Choice and Affordability
4. Lowering Drug Prices
5. Price Transparency
6. Rethinking Rural Health
7. Protecting Taxpayer Dollars
8. eMedicare
9. Ensuring Safety & Quality
10. Patients Over Paperwork
11. Fostering Innovation
12. MyHealthEData
13. Fighting The Opioid Epidemic
14. Better Care for Dual Eligibles
15. Innovative Payment Models
16. Modernizing CMS

This performance budget reflects CMS' vision by investing in our people, processes, structure, and capabilities. CMS will continue to build on successes of previous years focusing all of its authority and programs on one objective: transforming the health care system to deliver better value and results for patients through competition and innovation. CMS is holding the entire health care system—health plans, states, contractors, providers, clinicians—accountable by encouraging choice and competition to develop new tools and solutions that will allow the system to deliver value to patients.

We take our role seriously in leading efforts to improve the quality and affordability of health care for all Americans; drive American health care towards payment for value, not volume, and, lower the rate of growth in America's health care spending.

The investments proposed in FY 2021 will keep CMS on the leading edge of providing high quality healthcare that all Americans deserve, while also pursuing program integrity methods to "Pay it Right" and better prevent fraudulent or improper payments.

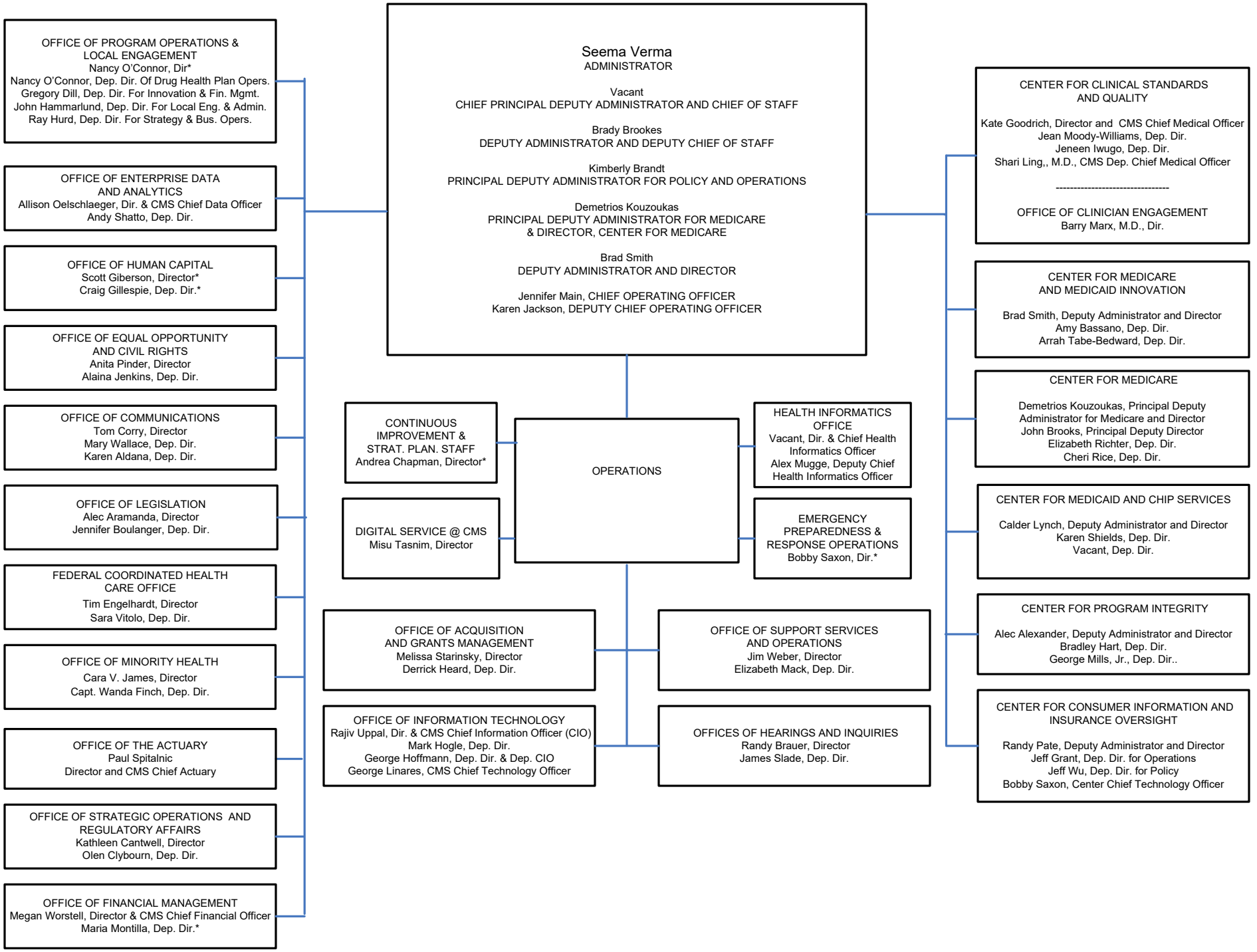
On behalf of all those we serve, I thank you for your continued support of CMS and its FY 2021 performance budget.

Seema Verma

Org Chart Text Version

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED as of February 3, 2020
* Acting



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EXECUTIVE SUMMARY

Agency Overview

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). CMS oversees the two largest Federal health care programs - Medicare and Medicaid - as well as the Children's Health Insurance Program (CHIP) and the Exchanges. CMS' programs will touch the lives of over 145 million beneficiaries and consumers in FY 2021. CMS takes its role very seriously, as our oversight responsibilities impact millions of citizens and continue to grow dramatically.

As a committed steward of public funds, CMS is dedicated to moving toward a health care system that will drive down costs, give Americans more choices, and put patients and doctors in control of their health care. To achieve this, CMS will empower patients and doctors to make decisions about their health care while reducing burdensome regulations and building a patient-centered system of care that increases competition, quality, and access.

CMS works closely with its customers and other stakeholders to provide oversight as well as foster innovation and collaboration.

CMS touches the lives of Americans by providing coverage that offers peace of mind, transforms health care by reducing disparities, strengthens program integrity by reducing fraud, waste, and abuse, and promotes innovation. CMS supports innovative approaches to improve quality, accessibility, and affordability.

Overview of Budget Request

CMS requests funding for four annually-appropriated accounts including Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, and Payments to the Health Care Trust Funds. The table below displays CMS' FY 2019 Final, FY 2020 Enacted, and FY 2021 Budget request levels for these accounts.

CMS' resource needs are principally driven by workloads that grow annually and by its role in leading national efforts to improve efficiency, health care quality, and access to care. The FY 2021 Budget request reflects a level of funding that will allow CMS to focus on base operations and improve its traditional activities in Medicare, Medicaid, and CHIP.

CMS' FY 2021 President's Budget includes a General Provision that assumes the Federal Exchange will operate almost entirely on mandatory user fees and a small amount of HCFAC resources.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Accounts	FY 2019 Final	FY 2020 Enacted	FY 2021 Request	FY 2021 +/- FY 2020
Program Management /1	$3,965.8	$3,974.7	$3,693.5	($281.2)
HCFAC – Discretionary	$765.0	$786.0	$813.0	$27.0
Grants to States for Medicaid	$411,083.9	$422,175.0	$453,807.2	$31,632.2
Payments to Health Care Trust Funds	$378,343.8	$410,796.1	$439,514.0	$28,717.9
Grand Total	**$794,158.5**	**$837,731.8**	**$897,827.7**	**$60,095.9**

/1 FY 2019 Final Program Management total is reduced to reflect the HHS Secretary Transfer Authority

Key Initiatives

Value-Based Healthcare

The FY 2021 President's Budget will help CMS promote a more competitive healthcare system that delivers affordable, high-quality care at a sustainable cost. CMS remains committed to its goal of empowering consumers, focusing on outcomes, and reforming payments. This Budget will strengthen the Medicare and Medicaid programs by supporting initiatives to transform Medicare into a more affordable, patient-driven program that encourages innovation and competition, while encouraging participation from states in Medicare and Medicaid innovation models. This Budget will also promote price transparency via program reforms that empower patients to drive value, by providing accurate, comprehensive, and actionable cost and quality information.

Transforming Medicaid and CHIP Operations

CMS continues to give states even greater flexibility in their Medicaid programs as they move toward more accountable, value-based payment delivery systems. This Budget makes strategic investments in the Medicaid and CHIP Scorecard and the Medicaid and CHIP Business Information Solution (MACBIS). Both of these efforts aggregate the operational and programmatic data needed for CMS' program monitoring, technical assistance, and oversight activities, and provide the tools needed to hold states accountable for achieving better health outcomes and results.

Invest in Program Integrity

In FY 2021, CMS will continue to invest in program integrity activities. Program Integrity, or very simply, "pay it right" must focus on paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries while taking aggressive actions to root out fraud, waste, and abuse. Our program integrity activities for Medicare, Medicaid, and the Federal Exchange help us to hold health care systems

accountable, protect our beneficiaries and consumers from harm, and safeguard taxpayer dollars while minimizing unnecessary provider burden. By investing in activities to prevent fraud, waste, and abuse in its programs, CMS strikes an important balance by preventing and addressing potentially fraudulent and improper payments while ensuring CMS oversight supports, and does not impede, efficient, high-quality health care. The Budget also supports provider enrollment and screening activities, enforcement efforts, and advanced data analytics. CMS is also intensifying its program integrity efforts by utilizing innovative strategies such as artificial intelligence and appropriate private sector best practice methods to fight against fraud, waste, and abuse. The return on investment for HCFAC law enforcement activities was $4 returned for every $1 expended from 2016 to 2018.

Reducing Prescription Drug Costs

This Budget supports CMS' efforts to improve access to prescription drugs and reduce out-of-pocket costs for Medicare and Medicaid beneficiaries. CMS recently finalized changes to the Part C and Part D programs that provide plans with greater negotiating tools and empower beneficiaries to select a plan that best meets their needs. CMS is also working to improve transparency under Part D, through changes like requiring all plans to provide clinicians with access to drug price information through a real-time electronic benefit tool that integrates with their electronic medical record system, and by including information on drug price increases and lower-cost therapeutic alternatives in beneficiaries' monthly "explanations of benefits". Under the Medicaid program, CMS has approved value-based purchasing agreements at the request of a number of states as an innovative way to lower drug costs. CMS has also improved transparency through the release of updated Medicare and Medicaid data on the CMS Drug Spending Dashboards and new data on drug wastage under Medicare Part B.

Proposed Law

The Budget includes $200 million in mandatory Program Management funding to implement a comprehensive package of CMS legislative proposals to carry out Administration reforms to CMS programs.

National Medicare & You Education Program (NMEP) User Fee

The Budget includes a proposal that allows CMS to assess an increased amount of user fees from Medicare Advantage and Part D plans to more equitably support outreach and enrollment assistance activities provided by the National Medicare Education Program.

Change Medicare Beneficiary Education Requirements

The Budget includes a proposal that provides the Secretary with increased flexibility to determine how to most efficiently and effectively communicate Medicare benefits information included in the Medicare & You Handbook with beneficiaries, including providing information through electronic means as opposed to paper copies in some cases.

Tailor the Frequency of Skilled Nursing Facility Surveys to More Efficiently Use Resources and Alleviate Burden for Top Performing Nursing Homes

The Budget includes a proposal that gives the Secretary authority to adjust statutorily required survey frequencies for top-performing skilled nursing facilities and reinvest resources to strengthen oversight and quality improvement for poor performing facilities.

Charge Long-Term Care Facilities Fees for Revisit Surveys

The Budget proposes to allow CMS to charge long-term care facilities fees for revisits required to validate correction of deficiencies identified during initial and re-certification visits or facility-reported incidents. Fees would cover associated costs necessary to perform revisit surveys. This proposal incentivizes quality of care and resident well-being.

Two Year Budget Authority for Survey and Certification

The Budget includes two-year budget authority for the Survey and Certification Program.

Availability of CMS Exchange User Fee

The Budget includes a proposal allowing user fees collected for the operation of the Federally-facilitated Exchange and State-based Exchanges that use the Federal Platform to be available for any Federal administrative expenses associated with operating Exchange activities. These activities consist of enrollment, eligibility verification, issuer payment activities, quality work, and associated IT.

FY 2021 Budget Request

Program Management

In FY 2021, CMS requests $3,693.5 million in discretionary funding. CMS' request reflects funding needed to process Medicare claims and service the continued growth in CMS' traditional programs. The request supports CMS' priorities of supporting innovative approaches to improve quality, accessibility and affordability, and improving the customer experience.

- Program Operations:

  CMS' FY 2021 Budget request for Program Operations is $2,478.8 million, a decrease of $346.0 million below the FY 2020 Enacted level. This request will allow CMS to continue operating Medicare, Medicaid, CHIP, and basic CMS support programs. The request includes a General Provision to allow Exchange user fees to cover all Federal administrative expenses associated with operating the Federally-facilitated Exchange (FFE) and federal platforms leveraged by State-based Exchanges using the Federal Platform (SBE-FPs). Additionally, the request allows CMS to continue to reinvent Medicaid operations by improving data systems and increasing transparency about program administration and outcomes through the Medicaid and CHIP Scorecard initiative. It also funds core outreach and education activities that positively impact the beneficiary experience and CMS' customer service goals and invests in essential cybersecurity activities. Further, the request

includes funding for ongoing research projects such as the Medicare Current Beneficiary Survey (MCBS) and the Chronic Condition Warehouse (CCW), as well as several other research related activities. CMS will continue to invest in high priority activities with a focus on high quality service for beneficiaries and participating providers and will continue evaluating areas for contract efficiencies to maximize resources.

- Federal Administration:

  CMS' FY 2021 Budget request for Federal Administration is $772.5 million, an increase of $40.0 million above the FY 2020 Enacted level. Of this request, $711.0 million supports 4,286 direct FTEs, which is 64 FTEs higher than the FY 2020 level of 4,222. This request assumes a 1.0 percent cost of living allowance (COLA) for civilian employees and 2.6 percent COLA for Commissioned Corp staff. The remaining request supports administrative information technology, communication, utilities, rent and space requirements, as well as administrative contracts and inter-agency agreements.

- Survey and Certification:

  CMS' FY 2021 Budget request for Survey and Certification totals $442.2 million, an increase of $44.9 million above the FY 2020 Enacted level. This request helps ensure appropriate survey oversight of all Medicare and Medicaid participating providers, including nursing homes, home health agencies, hospices, hospitals, organ transplant facilities, end-stage renal disease (ESRD) providers, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics, community mental health centers, and ambulatory surgery centers. The Budget request also supports contracts to strengthen quality improvement and national program consistency, promote gains in efficiency, make oversight of accrediting organizations more effective, and implement key recommendations made by the Government Accountability Office (GAO). The Budget includes a proposal for two-year budget authority as well as a new mandatory revisit user fee for the Survey and Certification Program.

Health Care Fraud and Abuse Control

CMS requests $813.0 million in discretionary HCFAC funding in FY 2021, an increase of $27.0 million above the FY 2020 Enacted level. This funding will allow CMS and its law enforcement partners to continue investing in activities that will reduce fraud in Medicare, Medicaid, CHIP, and the Federally-facilitated Exchange. This includes ongoing investments in the oversight of Medicare Parts C and D; state-of-the-art analytic technology to detect and prevent improper payments; support for Medicare Strike Forces used to identify and prosecute fraudulent providers; and pre-enrollment provider screening.

In FY 2021, CMS plans to place more emphasis in the following areas: pre-pay claims review with the aid of predictive analytics; streamlining provider enrollment initiatives and simplifying documentation requirements to more efficiently address fraud and improper payments while also reducing provider burden; increasing communication and data sharing with internal and external stakeholders; and enhancing States' abilities to detect and deter fraud and abuse. CMS also plans to expand its use of prior authorization for durable medical equipment, prosthetics and orthotics (DMEPOS) with the goal of reducing improper

payments regarding certain vulnerable items. CMS' request includes funding for program integrity work in the Federally-facilitated Exchange, including measuring and reporting improper payments, conducting investigations and data analyses, and verifying agent and broker licensure. It also provides resources to fund new and expanded activities outlined in the Medicaid Program Integrity Strategy.

Grants to States for Medicaid

The FY 2021 Medicaid request is $453,807.2 million, an increase of $31,632.2 million above the FY 2020 Estimate. Continued increases in grants to states are required as Medicaid enrollment and health care costs continue to grow. This appropriation consists of $313,904.1 million for FY 2021 and $139,903.1 million in an advance appropriation from FY 2020 Enacted. These funds will help finance $493,269.2 million in estimated gross obligations in FY 2021. These obligations consist of:

- $465,149.2 million in Medicaid medical assistance benefits;
- $23,168.6 million for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $4,951.4 million for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2021 request for Payments to the Health Care Trust Funds account totals $439,514.0 million, an increase of $28,717.9 million above the FY 2020 Enacted level. This account transfers payments from the General Fund to the trust funds in order to make the Supplementary Medical Insurance (SMI) Trust Fund and the Hospital Insurance (HI) Trust Fund whole for certain costs, initially borne by the trust funds, which are properly chargeable to the General Fund. The largest transfer provides the General Fund contribution to the SMI Trust Fund for the General Fund's share of the SMI program. Other transfers include payments from the General Fund to the HI and SMI Trust Funds including the Medicare Prescription Drug Account, for costs such as general revenue for prescription drug benefits, HCFAC, and other administrative costs that are properly chargeable to the General Fund. The change in CMS' request for FY 2021 is largely driven by increases for the General Fund contributions for the SMI Trust Fund and Part D benefits.

Conclusion

CMS' FY 2021 request for its four annually-appropriated accounts—Program Management, discretionary HCFAC, Grants to States for Medicaid, and Payments to the Health Care Trust Funds—is $897,827.7 million, an increase of $60,095.9 million above the FY 2020 Enacted level.

CMS' FY 2021 total discretionary appropriated request for Program Management is $3,693.5 million. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs.

CMS requests $813.0 million in discretionary HCFAC funds. This funding will be devoted to maintaining and improving oversight of its programs related to early detection and prevention, and reducing fraud and all other improper payments.

CMS remains committed to finding efficiencies within base workloads, safeguarding its programs, and providing beneficiaries, stakeholders, and health care consumers with high quality levels of service.

Overview of Performance

CMS supports the Administration's goals to make government more effective, efficient, and customer-focused in managing and delivering HHS programs by implementing the Government Performance and Results Act of 1993 (GPRA) and GPRA Modernization Act of 2010 (GPRA-MA). CMS performance measures highlight fundamental program purposes and focus on the agency's role as an efficient and effective steward of taxpayer dollars. This performance budget makes recommendations that are consistent with the Administration's work to advance patient-centered health care and putting people first. We continue to work on aligning our performance commitments to the CMS and HHS strategic goals. CMS continues to track many of its established performance measures and works to introduce improvements that reflect the Administration's priorities.

CMS uses performance information to identify opportunities for improvement and to shape and improve its programs. The use of performance measures also provides a method of clear communication of CMS programmatic objectives to partners, such as states and national professional organizations. Performance data help shape policy and management choices in both the short and long term.

The CMS FY 2021 Performance section is designed to create a more complete presentation of performance commitments, accomplishments, and trends that reflect the Administration's vision.

All-Purpose Table (Comparable)
The Centers for Medicare & Medicaid Services
(Dollars in Millions)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 President's Budget +/- FY 2020 Enacted
Program Operations /1	$ 2,815.875	$ 2,824.823	$ 2,478.823	$ (346.000)
Federal Administration	$ 732.533	$ 732.533	$ 772.533	$ 40.000
State Survey & Certification	$ 397.334	$ 397.334	$ 442.192	$ 44.858
Research /2	$ 20.054	$ 20.054	$ -	$ (20.054)
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$ 3,965.796**	**$ 3,974.744**	**$ 3,693.548**	**$ (281.196)**
MIPPA (Mandatory; P.L. 110-275)	$ 2.814	$ 2.823	$ 3.000	$ 0.177
PAMA (P.L. 113-93)	$ 9.380	$ 9.410	$ 10.000	$ 0.590
IMPACT (P.L. 113-185)	$ 17.470	$ 5.293	$ 5.625	$ 0.332
MACRA (P.L. 114-10)	$ 107.870	$ 18.820	$ -	$ (18.820)
BBA (P.L. 115-123)	$ 20.500	$ -	$ -	$ -
SUPPORT (P.L. 115-271)	$ 83.000	$ -	$ 10.000	$ 10.000
Health Extenders Sec. 1402 (P.L. 116-59)	$ -	$ 1.852	$ -	$ (1.852)
Further Health Extenders Sec. 1402 (P.L. 116-69)	$ -	$ 1.033	$ -	$ (1.033)
Further Consolidated Appropriations Act (P.L. 116-94)	$ -	$ 15.315	$ 5.000	$ (10.315)
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)	**$ 241.034**	**$ 54.546**	**$ 33.625**	**$ (20.921)**
Total, Appropriation/BA Current Law (0511)	**$ 4,206.830**	**$ 4,029.290**	**$ 3,727.173**	**$ (302.117)**
Proposed Law Appropriation (Mandatory) /3	$ -	$ -	$ 200.000	$ 200.000
Total, Appropriation/BA Proposed Law (0511)	**$ 4,206.830**	**$ 4,029.290**	**$ 3,927.173**	**$ (102.117)**
Est. Offsetting Collections from Non-Federal Sources: /4				
User Fees and Reimbursements	$ 243.020	$ 248.765	$ 257.800	$ 9.035
Exchange User Fees (FFE)	$ 1,785.860	$ 1,701.893	$ 1,479.692	$ (222.201)
Risk Adjustment User Fees (RA)	$ 38.608	$ 50.063	$ 46.000	$ (4.063)
Recovery Audit Contracts	$ 309.942	$ 359.933	$ 500.000	$ 140.067
Total, Offsetting Collections	**$ 2,377.430**	**$ 2,360.654**	**$ 2,283.492**	**$ (77.162)**
Subtotal, New BA, Current Law	**$ 6,584.260**	**$ 6,389.944**	**$ 6,010.665**	**$ (379.279)**
Proposed Law (Discretionary)	$ -	$ -	$ -	$ -
Program Level, Proposed Law (0511)	**$ 6,584.260**	**$ 6,389.944**	**$ 6,210.665**	**$ (179.279)**
HCFAC Discretionary	**$ 765.000**	**$ 786.000**	**$ 813.000**	**$ 27.000**
Non-CMS Administration /5	**$ 2,703.000**	**$ 2,715.500**	**$ 3,077.900**	**$ 362.400**
CMS FTEs:				
Discretionary (Federal Administration)	4,360	4,222	4,286	64
Reimbursable (CLIA, CoB, RAC, Exchange)	273	309	309	0
Mandatory (Direct Appropriations)	151	126	74	-52
Subtotal, Program Management FTEs	**4,784**	**4,657**	**4,669**	**12**
Program Management, Proposed Law	0	0	0	0
Total, Program Management FTEs	**4,784**	**4,657**	**4,669**	**12**
HCFAC (Mandatory)	426	446	446	0
Medicaid Integrity (State Grants; Mandatory)	189	206	206	0
Affordable Care Act Section 3021 (Mandatory)	533	574	574	0
Quality Improvement Organizations	247	262	267	5
Demonstrations	11	11	11	0
Subtotal, Other Sources FTEs	**1,406**	**1,499**	**1,504**	**5**
Total, CMS FTEs	**6,190**	**6,156**	**6,173**	**17**

/1 FY 2019 reflects the use of HHS Secretary's Transfer Authority totaling $8.948 million.

/2 In FY 2021, Research funding is being requested within the Program Operations account.

/3 Includes $200 million in administrative funding to implement the CMS proposals in the FY 2021 President's Budget.

/4 FY 2019 and FY 2020 collections are net of sequester and/or pop-up authority; FY 2021 are gross estimated collections.

/5 Includes funds for the SSA, DHHS/OS, MedPAC, and the SHIPs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Program Management

Appropriations Language

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare *&* Medicaid Services, not to exceed **[**$3,974,744,000**]** *$3,693,548,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act*;* together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 1893(h) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further*, That the Secretary is directed to collect fees in fiscal year **[**2020**]** *2021* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act: *Provided further, That* **[**amounts available under this heading to support quality improvement organizations (as defined in section 1152 of the Social Security Act) shall not exceed the amount specifically provided for such purposes under this heading in division H of the Consolidated Appropriations Act, 2018 (Public Law 115-141)**]** *of the funds made available under this heading, $442,192,000 shall remain available until September 30, 2022, and shall be available for the Survey and Certification Program*. *(Department of Health and Human Services Appropriations Act, 2020.)*

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare *&* Medicaid Services, not to exceed **[**$3,669,744,000**]** *$3,693,548,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act*;*	Provides a one-year appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid, Children's Health Insurance, and consumer information and insurance oversight and protection programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 1893(h) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended:	Provides funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fee collections. Authorizes the collection of fees for the sale of data, and other authorized user fees and offsetting collections to cover administrative costs, including those associated with providing data to the public, and other purposes. All of these collections are available to be carried over from year to year, until expended.
Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation:	Authorizes the crediting of HMO user fee collections to the Program Management account.
Provided further, That the Secretary is directed to collect fees in fiscal year **[**2020**]** *2021* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act	Authorizes the collection of user fees from Medicare Advantage organization for costs related to enrollment, dissemination of information and certain counseling and assistance programs.

Language Provision	**Explanation**
Provided further, That of the funds made available under this heading, $442,192,000, to remain available until September 30, 2022, shall be available for the Survey and Certification Program.	Extends the period of availability of Survey and Certification funding to two-year.
[*Provided further,* That amounts available under this heading to support quality improvement organizations (as defined in section 1152 of the Social Security Act) shall not exceed the amount specifically provided for such purposes under this heading in division H of the Consolidated Appropriations Act, 2018 (Public Law 115-141)**]**.	Reduces flexibility in funding quality-related activities.

General Provisions

Language Provision	Explanation
SEC. XXX. For fiscal year 2021 and each subsequent fiscal year, the notification requirements described in sections 1804(a) and 1851(d) of the Social Security Act may be fulfilled by the Secretary in a manner similar to that described in paragraphs (1) and (2) of section 1806(c) of such Act.	Authorizes the Secretary to allow beneficiaries to opt to receive the Medicare & You Handbook and the Medicare Advantage open season notification through electronic means rather than through the mail. This is a modernization and efficiency measure that would decrease the number of Handbooks that are mailed and would reduce the substantial cost of mailing Medicare & You Handbooks to millions of beneficiaries annually.
SEC. XXX. Any assessment or user fee charged pursuant to section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act credited to the "Centers for Medicare and Medicaid Services – Program Management" account shall be available for any other Federal administrative expenses the Secretary incurs for activities related to the Exchange program, in addition to any other purposes authorized by law and shall remain available until expended for the purposes described in this section	This provision allows for user fees collected for the operation of Federally-Facilitated Exchanges and State-Based Exchanges that use the Federal Platform to be used on any federal administration Exchange-related operating activity. Currently, activities that CMS conducts on behalf of all Exchanges are not eligible to be paid for by user fees. These activities include enrollment eligibility verification, issuer payment activities, quality work, and associated IT.

CMS Program Management

Amounts Available for Obligation

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS) /1	$3,965,796,120	$3,974,744,000	$3,693,548,000
Trust Fund Mandatory Appropriation:			
PAMA/SGR (PL 113-93)	$9,380,000	$9,410,000	$10,000,000
IMPACT Act (PL 113-185)	$17,470,250	$5,293,125	$5,625,000
MACRA (PL 114-10)	$107,870,000	$18,820,000	$0
BBA (PL 115-123)	$20,500,000	$0	$0
SUPPORT (PL 115-271)	$83,000,000	$0	$10,000,000
Health Extenders (116-59)	$0	$1,852,000	$0
Further Health Extenders (116-69)	$0	$1,033,000	$0
Further Consolidated Appropriation (116-94)	$0	$15,315,000	$5,000,000
Subtotal, trust fund mand. Appropriation /2	$238,220,250	$51,723,125	$30,625,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$2,814,000	$2,823,000	$3,000,000
Subtotal, trust fund mand. Appropriation /2	$2,814,000	$2,823,000	$3,000,000
Offsetting Collections from Non-Federal Sources:			
Sale of data user fees	$30,753,869	$20,000,000	$20,000,000
Exchange user fees (FFE)	$1,785,859,733	$1,701,892,741	$1,479,692,085
Risk Adjustment user fees (RA)	$38,607,874	$50,063,200	$46,000,000
Recovery audit contracts	$309,942,011	$359,932,500	$500,000,000
CLIA user fees	$56,222,477	$60,600,400	$64,400,000
Part D COB user fees	$44,635,540	$38,581,000	$43,000,000
MA/PDP user fees	$87,768,400	$84,487,600	$84,000,000
Provider enrollment user fees	$23,640,210	$29,664,005	$30,000,000
Civil Monetary Penalties	$0	$15,432,400	$16,400,000
Subtotal, offsetting collections /3	$2,377,430,114	$2,360,653,846	$2,283,492,085
Total Budget Authority	**$6,584,260,484**	**$6,389,943,971**	**$6,010,665,085**

/1 FY 2019 reflects the use of HHS Secretary's Transfer Authority totaling $8.948 million.
/2 Current law display. Net of sequester in FY 2019 and FY 2020.
/3 FY 2019 and FY 2020 amounts are net of sequester and pop-up authority; FY 2021 displays gross estimated collections.

Program Management

Summary of Changes

2020 Enacted	
Total estimated budget authority 1/	$3,974,744,000
(Obligations) 1/	($3,974,744,000)
2021 President's Budget	
Total estimated budget authority 1/	$3,693,548,000
(Obligations) 1/	($3,693,548,000)
Net Change	**($281,196,000)**

	FTE	2020 Estimate Budget Authority	FTE	Change from Base Budget Authority
Increases:				
A. Program:				
1. Program Operations		$2,824,823,000		$193,583,000
2. Federal Administration		$732,533,000		$40,000,000
3. State Survey & Certification		$397,334,000		$44,858,000
4. Research		$20,054,000		$0
Subtotal, Program Increases 1/				**$278,441,000**
Total Increases 1/				**$278,441,000**
Decreases:				
A. Program:				
1. Program Operations		$2,824,823,000		($539,583,000)
2. Federal Administration	4,222	$732,533,000	64	$0
3. State Survey & Certification		$397,334,000		$0
4. Research		$20,054,000		($20,054,000)
Subtotal, Program Decreases 1/				**($559,637,000)**
Total Decreases 1/				**($559,637,000)**
Net Change 1/				**($281,196,000)**

1/ Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.

CMS Program Management
Budget Authority by Activity
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
1. Program Operations /1	$2,510,875	$2,519,823	$2,478,823
Additional Medicare Operations Funding	$305,000	$305,000	$0
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
PAMA/SGR (PL 113-93)	$10,000	$10,000	$10,000
IMPACT Act (PL 113-185)	$13,000	$0	$0
MACRA (PL 114-10)	$115,000	$20,000	$0
BBA (115-123)	$20,500	$0	$0
SUPPORT (115-271)	$83,000	$0	$10,000
Health Extenders (116-59)	$0	$1,852	$0
Further Health Extenders (116-69)	$0	$1,033	$0
Further Consolidated Appropriation (116-94)	$0	$15,315	$5,000
Sequester	($8,742)	($1,947)	$0
Subtotal, Program Operations	**$3,051,633**	**$2,874,076**	**$2,506,823**
(Obligations)	($3,049,452)	($2,824,823)	($2,478,823)
2. Federal Administration	$732,533	$732,533	$772,533
Sequester	$0	$0	$0
Subtotal, Federal Administration	**$732,533**	**$732,533**	**$772,533**
(Obligations) /2	($749,422)	($732,533)	($772,533)
3. State Survey & Certification	$397,334	$397,334	$442,192
IMPACT Act (PL 113-185)	$5,625	$5,625	$5,625
Sequester	($349)	($332)	$0
Subtotal, State Survey & Certification	**$402,610**	**$402,627**	**$447,817**
(Obligations)	($400,998)	($402,627)	($447,817)
4. Research, Demonstration & Evaluation /3	$20,054	$20,054	$0
Sequester	$0	$0	$0
Subtotal, Research, Demonstration & Evaluation	**$20,054**	**$20,054**	**$0**
(Obligations)	($20,029)	($20,054)	$0
5. Reimbursables	$2,404,588	$2,377,901	$2,283,492
Sequester	($147,178)	($139,116)	$0
Sequester Pop-Up	$120,020	$121,869	$0
Subtotal, User Fees	**$2,377,430**	**$2,360,654**	**$2,283,492**
(Obligations)	($1,699,830)	($1,790,246)	($1,570,900)
Total, Budget Authority /4	**$6,584,260**	**$6,389,944**	**$6,010,665**
(Obligations)	**($5,919,731)**	**($5,770,283)**	**($5,270,073)**
FTE /5	**4,784**	**4,657**	**4,669**

/1 FY 2019 reflects the use of HHS Secretary's Transfer Authority totaling $8.948 million.
/2 FY 2019 obligations include administrative cost reimbursements from external agencies.
/3 In FY 2021, the Research request is included in Program Operations.
/4 Reflects CMS' current law request.
/5 Includes direct and reimbursable FTEs only.

CMS Program Management
Authorizing Legislation

	FY 2020 Amount Authorized	FY 2020 Enacted	FY 2021 Amount Authorized	FY 2021 President's Budget
Program Management:				
1. Research:				
a) Social Security Act, Title XI				
- Section 1110	Indefinite	Indefinite		
- Section 1115 1/	$ 2,000,000	$ 2,000,000		
b) P.L. 92-603, Section 222	Indefinite	Indefinite		
c) P.L. 90-248, Section 402	Indefinite	Indefinite		
d) Social Security Act, Title XVIII	Indefinite	Indefinite		
2. Program Operations:				
Social Security Act, Titles XI, XVIII, XIX and XXI	Indefinite	Indefinite	Indefinite	Indefinite
a) Social Security Act, Title XI				
- Section 1110			Indefinite	Indefinite
- Section 1115 1/			$ 2,000,000	$ 2,000,000
b) P.L. 92-603, Section 222			Indefinite	Indefinite
c) P.L. 90-248, Section 402			Indefinite	Indefinite
d) Social Security Act, Title XVIII			Indefinite	Indefinite
3. State Certification:				
Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs:				
Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
6. MA/PDP:				
Social Security Act, Section 1857(e)(2) Balanced Budget Refinement Act of 1999 Medicare Prescription Drug, Improvement and Modernization Act of 2003	2/	2/	2/	2/
7. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
8. Provider Enrollment:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Section 6401, amended	2/	2/	2/	2/
9. Exchanges:				
Patient Protection and Affordable Care Act P.L. 111-148/152 Sections 1311 and 1321; 31 USC 9701.	Indefinite	Indefinite	Indefinite	Indefinite
10. Recovery Audit Contractors:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level	$ -	$ -	$ -	$ -
Total request level against definite authorizations	$ -	$ -	$ -	$ -

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2021.
2/ Limits authorized user fees to an amount computed by formula.

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2012				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Subtotal				$113,000,000
Trust Fund Appropriation:				
Base	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,879,476,000
Rescissions (P.L. 112-74)	$0	$0	$0	($7,249,000)
MIPPA (PL 110-275)	$0	$0	$0	$35,000,000
ACA (PL 111-148/152)	$0	$0	$0	$25,302,000
Subtotal	$4,396,973,000	$3,173,005,000	$4,044,876,000	$3,932,529,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
2013				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Transfers	$0	$0	$0	$453,803,000
Sequestration	$0	$0	$0	($5,763,000)
Subtotal				$561,040,000
Trust Fund Appropriation:				
Base	$4,820,808,000	$0	$4,370,112,000	$3,872,227,000
Transfers (P.L. 113-6)	$0	$0	$0	$113,588,000
Rescissions (P.L. 113-6)	$0	$0	$0	($7,656,000)
Sequestration	$0	$0	$0	($194,827,000)
ATRA (PL 112-240)	$0	$0	$0	$17,500,000
ACA (PL 111-148/152)	$0	$0	$0	$25,440,000
Sequestration	$0	$0	$0	($2,190,000)
Subtotal	$4,820,808,000	$0	$4,370,112,000	$3,824,082,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($7,140,000)
2014				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$110,000,000
Sequestration	$0	$0	$0	($8,136,000)
Subtotal				$104,864,000
Trust Fund Appropriation:				
Base **1/**	$5,217,357,000	$0	$5,217,357,000	$3,974,744,000
Transfers (P.L. 113-76)	$0	$0	$0	$118,582,000
Sequestration	$0	$0	$0	($1,584,000)
ACA (PL 111-148/152)	$0	$0	$0	$25,341,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$48,500,000
Sequestration	$0	$0	$0	($1,825,000)
Subtotal	$5,217,357,000	$0	$5,217,357,000	$4,163,758,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,080,000)

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2015				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0	$50,000,000
Sequestration	$0	$0	$0	($3,869,000)
Subtotal				$49,131,000
Trust Fund Appropriation:				
Base **1/**	$4,199,744,000	$0	$0	$3,974,744,000
ACA (PL 111-148/152)	$0	$0	$0	$5,559,200
Sequestration	$0	$0	$0	($408,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$204,500,000
IMPACT Act (PL 113-185)	$0	$0	$0	$107,333,000
Subtotal	$4,199,744,000	$0	$0	$4,297,728,200
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Sequestration	$0	$0	$0	($10,220,000)
2016				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($204,000)
Subtotal				$2,796,000
Trust Fund Appropriation:				
Base **1/ 2/**	$4,245,186,000	$0	$0	$3,970,785,000
ACA (PL 111-148/152)	$0	$0	$0	$353,000
Sequestration	$0	$0	$0	($1,883,000)
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$216,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
Subtotal	$4,245,186,000	$0	$0	$4,212,588,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$65,000,000
Sequestration	$0	$0	$0	($4,420,000)
2017				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($207,000)
Subtotal				$2,793,000
Trust Fund Appropriation:				
Base **1/ 2/**	$4,109,549,000	$0	$0	$3,966,314,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$211,000,000
21st Century Cures (PL 114-255)	$0	$0	$0	$18,000,000
Sequestration	$0	$0	$0	($16,444,977)
Subtotal	$4,109,549,000	$0	$0	$4,206,202,023

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2018				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($198,000)
Subtotal				$2,802,000
Trust Fund Appropriation:				
Base **1/ 2/**	$3,587,996,000	$3,451,141,000	$3,974,744,000	$3,964,880,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$163,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
21st Century Cures Act (PL 114-255)	$0	$0	$0	$12,000,000
BB Act '18 (PL 115-123)	$0	$0	$0	$35,500,000
Sequestration	$0	$0	$0	($13,175,250)
Subtotal	$3,587,996,000	$3,451,141,000	$3,974,744,000	$4,186,829,750
2019				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($186,000)
Subtotal				$2,814,000
Trust Fund Appropriation:				
Base **1/ 2/**	$3,543,879,000	$3,502,024,000	$3,974,744,000	$3,965,796,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$115,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
BB Act '18 (PL 115-123)	$0	$0	$0	$20,500,000
SUPPORT Act (PL 115-271)	$0	$0	$0	$83,000,000
Sequestration	$0	$0	$0	($8,904,750)
Subtotal	$3,543,879,000	$3,502,024,000	$3,974,744,000	$4,204,016,250
2020				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($177,000)
Subtotal				$2,823,000
Trust Fund Appropriation:				
Base **1/**	$3,579,427,000	$3,984,744,000	$3,974,744,000	$3,974,744,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$20,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
Health Extenders (PL 116-59)	$0	$0	$0	$1,852,000
Further Health Extenders (PL 116-69)	$0	$0	$0	$1,033,000
Further Consolidated Appropriation (PL 116-9	$0	$0	$0	$15,315,000
Sequestration	$0	$0	$0	($2,101,875)
Subtotal	$3,579,427,000	$3,984,744,000	$3,974,744,000	$4,026,467,125
2021				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	$0
Subtotal				$3,000,000
Trust Fund Appropriation:				
Base **3/**	$3,693,548,000	$0	$0	$0
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$5,625,000
SUPPORT Act (PL 115-271)	$0	$0	$0	$10,000,000
Further Consolidated Appropriation (PL 116-9	$0	$0	$0	$5,000,000
Sequestration	$0	$0	$0	$0
Subtotal	$3,693,548,000	$0	$0	$30,625,000

1/ Base appropriation includes $305 million to support Program Management activity related to the Medicare Program.

2/ Reduced to reflect HHS Secretary's Transfer in a given Fiscal Year.

3/ Based on Current Law Request

CMS Program Management
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2020

CMS Program Management has no appropriations not authorized by law.

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Program Operations
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA 1/	$2,815,875	$2,824,823	$2,478,823	($346,000)

1/ FY 2019 Final includes $8.948 million in HHS Secretary's Transfer Authority (STA).

Medicare Authorizing Legislation – Social Security Act, Title XVIII, Sections 1816 and 1842, 42 U.S.C. 1395 and the Medicare Prescription Drug Improvement and Modernization Act of 2003.

Medicaid Authorizing Legislation – Social Security Act, Title XIX, Section 1901

Children's Health Insurance Program Authorizing Legislation – Social Security Act, Title XXI

Affordable Care Act Authorizing Legislation – Patient Protection and Affordable Care Act (Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152)

FY 2020 Authorization – One Year/Multi-Year P.L. 116-94

Allocation Method – Contracts, Competitive Grants, Cooperative Agreements

OVERVIEW

CMS administers and oversees the nation's largest ongoing health care programs. These programs include the Medicare program, established in 1965 for Americans age 65 and older and for disabled persons, including those with End-Stage Renal Disease (ESRD); the Medicaid program, also established in 1965, for low-income families and aged, blind, and disabled individuals; the Children's Health Insurance Program (CHIP), established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels; and the consumer-based Health Insurance Exchanges.

Program Operations primarily funds the processing of Medicare Fee-For-Service (FFS) claims, the National Medicare Education program, information technology (IT) infrastructure, and operational support. It supports Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement related activities, and ongoing research. It also funds operations and enhancements in the Medicaid and CHIP programs, as well as insurance market reform and oversight.

As the primary account funding the operations for CMS' programs, Program Operations plays a direct role in achieving the Agency's strategic priorities by promoting efficiency in health care, reforming the health care delivery system, decreasing medical costs and payment error rates, creating a more efficient Medicare appeals system, and reducing burdens and regulations to those who serve our beneficiaries.

Program Description and Accomplishments

Medicare

Authorized in 1965 under title XVIII of the Social Security Act, the Medicare program provides hospital and supplemental medical insurance to Americans age 65 and older and to disabled persons, including those with ESRD. The program was expanded in 2006 with the introduction of a voluntary prescription drug benefit, Part D. Medicare enrollment has increased from 19 million in 1966 to a projected 64 million beneficiaries in FY 2021. Medicare benefits, that is, the payments made to providers, health plans, and drug plans for their services, are permanently authorized. The Medicare administrative expenses discussed in this chapter are funded annually through the CMS Program Management appropriation.

For Medicare Parts A and B, CMS processes providers' claims, funds beneficiary outreach and education, maintains the IT infrastructure needed to support various claims processing systems, and makes improvements to programs such as the Healthcare Integrated General Ledger and Accounting System (HIGLAS) and the administrative simplification provisions enacted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For Medicare Parts C and D, CMS funds certification of payments, operational support for programs such as Medicare claim appeals, oversight and monitoring functions, and audits of Medicare Advantage (MA), joint MA-prescription drug plans (MA-PDP), and standalone prescription drug plans (PDP).

Medicaid and CHIP

Authorized in 1965 under title XIX of the Social Security Act, Medicaid is a means-tested health care entitlement program financed jointly by states and the federal government that provides health care coverage to low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other adults. Medicaid also provides community based long-term care services and supports seniors and individuals with disabilities, as well as institutional care and long-term care services. As a result, Medicaid programs vary widely from state to state. The grants made to states for the federal share of Medicaid services and state administration of this program is appropriated annually. The funding for Medicaid included in the Program Operations chapter covers certain administrative expenses such as Medicaid systems support, managed care review and oversight, demonstration management, and other program-related initiatives.

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a federal-state matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. This program was the largest single expansion of

health insurance coverage for children in more than 30 years and has improved access to health care and quality of life for millions of vulnerable children younger than 19 years old.

Private Health Insurance Protections and Programs

CMS conducts market oversight of Qualified Health Plans (QHPs) and works in collaboration with states and issuers on Medical Loss Ratio (MLR) rules, oversight of State-based Exchanges (SBEs), financial assistance eligibility determination, and market stabilization activities. In states that have elected not to operate SBEs, CMS operates the Federal Exchanges on their behalf.

Program Operations Funding History

Fiscal Year (FY)	Budget Authority
FY 2017	$2,816,393,000
FY 2018	$2,814,959,000
FY 2019	$2,815,875,000
FY 2020 Enacted	$2,824,823,000
FY 2021 President's Budget	$2,478,823,000

*Funding levels include $8.43 million, $9.864 million, and $8.948 million in HHS Secretary's Transfer Authority for fiscal years 2017, 2018, and 2019, respectively.

Budget Request: $2,478.8 Million

CMS' FY 2021 President's Budget request for Program Operations is $2,478.8 million, a decrease of $346.0 million below the FY 2020 Enacted level. This request will allow CMS to operate Medicare, Medicaid, CHIP, and other CMS support programs. The request includes funding to implement the Durable Medical Equipment Competitive Bidding activities for the next round of bidding. It supports Medicare Quality Improvement and Value-Based Transformation activities and ongoing support for the Quality Payment Program (QPP). This request assumes a General Provision to expand the purpose of Exchange user fees to cover all Federal administrative expenses associated with operating the Federally-Facilitated Exchange (FFE) and federal platforms leveraged by State-based Exchanges on the Federal Platform (SBE-FPs). As such, no discretionary Program Management funding is included in the FY 2021 request for the Exchanges.

Additionally, CMS will continue transforming Medicaid operations by improving data systems and increasing transparency about program administration and outcomes through the Medicaid and CHIP Scorecard initiative. Other IT initiatives include Continuity of Operations/Disaster Recovery (COOP/DR) Program, cybersecurity, and Medicare Payment Systems Modernization (MPSM). CMS will continue to invest in high priority activities with a focus on high quality service for beneficiaries and participating providers and will continue evaluating areas for contract efficiencies to maximize resources.

Program Operations
(Dollars in Millions)

Activity	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Program Operations				
I. Medicare Parts A&B				
Ongoing Operations	$838.277	$853.326	$826.000	($27.326)
FFS Operations	$109.464	$110.782	$74.575	($36.207)
Claims Processing Investments	$78.990	$73.779	$78.050	$4.272
DME Competitive Bidding	$1.465	$26.792	$82.066	$55.274
II. Other Medicare Operational Costs				
Accounting and Audits	$105.920	$103.443	$94.597	($8.846)
QIC Operations	$77.790	$77.396	$77.790	$0.394
HIPAA Administrative Simplification	$26.090	$38.348	$22.212	($16.136)
Research 1/	$0	$0	$16.654	$16.654
III. Medicaid & CHIP				
Medicaid & CHIP	$148.124	$146.460	$126.300	($20.159)
IV. Health Care Planning & Oversight				
Part C&D IT Systems Investments	$33.710	$39.151	$29.792	($9.359)
Oversight & Management	$54.930	$85.858	$55.593	($30.265)
Exchanges	$229.491	$268.937	$0	($268.937)
V. Health Care Quality				
Health Care Quality	$53.663	$47.786	$67.000	$19.214
VI. Outreach & Education				
NMEP	$274.604	$273.697	$276.294	$2.597
Consumer Outreach	$8.170	$8.713	$4.500	($4.213)
VII. Information Technology				
IT Systems and Support	$639.032	$587.630	$450.000	($137.630)
VIII. Other Initiatives				
Opioids	$18.652	$14.463	$13.000	($1.463)
Medicare Quality Improvement - Value Based Transformation	$77.966	TBD	$144.400	--
Quality Payment Program	$0	$42.264	$40.000	($2.264)
Organizational Effectiveness	$24.174	$26.000	$0	($26.000)
Innovation and Modernization Effort	$15.362	$0	$0	$0
TOTAL 2/	**$2,815.875**	**$2,824.823**	**$2,478.823**	**($346.000)**

1/ CMS is requesting for Research to be funded under the Program Operations account in FY 2021.

2/ FY 2019 Final reflects an $8.948 million HHS Secretary's Transfer Authority adjustment. Totals may not add due to rounding.

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

Ongoing Operations

CMS processes beneficiary claims through Medicare Administrative Contractors (MACs). A MAC is a private healthcare insurer that has been awarded a geographical jurisdiction to process Medicare Part A and B medical claims or durable medical equipment claims for Medicare. In addition to processing Part A and Part B claims, MACs enroll providers in the Medicare program, handle provider reimbursement services, process first-level appeals, respond to provider inquiries, educate providers about the program, and administer the participating physician/supplier program (PARDOC). The MACs are the primary contracts for managing Medicare and are mission critical for the success of CMS.

The following table displays claims volumes for the period FY 2018 to FY 2021.

FFS Claims Volume
(Claim Count in Thousands)

Activity	FY 2018 Actual	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate
Part A (in thousands)	221,783	224,001	226,241	228,503
Part B (in thousands)	1,004,868	1,014,917	1,025,066	1,035,317
Total	**1,226,651**	**1,238,918**	**1,251,307**	**1,263,820**

Budget Request: $826.0 Million

The FY 2021 President's Budget request for Ongoing Operations is $826.0 million, a decrease of $27.3 million below the FY 2020 Enacted level. This request allows the MACs to continue processing Medicare claims accurately, in a timely manner, and in accordance with CMS' program requirements. The funding request supports a one percent increase in MAC workload and other provider service and claim management operations. MAC costs are slightly decreasing due to efficiencies gained and realized since integration and implementation of Part A and B claims processing contracts to the MACs, experience gained by the contractors and CMS, and cost saving legislation such as the ability to re-compete contracts up to once every ten years instead of once every five.

Medicare Administrative Contractors: $730.0 million.

In FY 2021, MACs are expected to:

- Process approximately 1.3 billion claims;
- Handle 2.3 million Medicare first-level appeal redeterminations;
- Answer 22.7 million provider toll-free inquiries.

Bills/Claims Payments – The MACs are responsible for processing and paying approximately 1.3 billion Part A bills and Part B claims correctly and timely. The MACs handle bills/claims from the wide range of healthcare providers, including hospitals, skilled nursing facilities, home health agencies, physicians, durable medical equipment suppliers,

clinical laboratories, and other providers and suppliers. Currently, almost all providers submit their claims in electronic format. The MACs also utilize electronic funds transfer to make the vast majority of Medicare benefit payments.

Provider Enrollment – CMS is responsible for both enrolling providers and suppliers into the Medicare program and ensuring that they continue to meet the enrollment requirements for their provider or supplier type. Program Operations supports the enrollment process for MACs. The enrollment process includes a number of verification processes to ensure that Medicare is only paying qualified providers and suppliers.

Provider Reimbursement Services – Medicare Part A providers are required to file a cost report on an annual basis. In addition to determining the payment amount for items paid on cost, the cost report is used to finalize Prospective Payment System (PPS) add-on payments such as graduate medical education, indirect medical education, disproportionate share hospital, and bad debt payments. The MACs perform many other payment review activities, maintain claims information systems, and are responsible for making determinations of status.

Medicare Appeals – The Medicare appeals process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse determination, including coverage and payment decisions. The first level of appeal begins at the MAC with a redetermination of the initial decision. MAC personnel not involved in the original determination review the original claim and any new information to determine if the original determination should be changed, and handle any reprocessing activities as required. The statute stipulates that MACs issue a decision within 60 calendar days of receipt of an appeal request. In FY 2020 and FY 2021, the MACs are expected to process 2.3 million redeterminations each fiscal year.

Participating Physician/Supplier Program (PARDOC) – This program helps reduce the impact of rising health care costs on beneficiaries by increasing the number of enrolled physicians and suppliers who “participate” in Medicare. Participating providers agree to accept Medicare-allowed payments as payment in full for their services. The MACs conduct an annual enrollment process and monitor limiting charge compliance to ensure that beneficiaries are not being charged more than Medicare allows.

Provider Inquiries and Toll-Free Service – CMS coordinates communication between Medicare contractors and providers to ensure consistent responses. To accomplish this, CMS requires the Medicare contractors to maintain a Provider Contact Center (PCC) that can respond to telephone and written (letters, e-mail, fax) inquiries. The primary goal of the PCC is to deliver timely, accurate, accessible, and consistent information to providers in a courteous and professional manner. These practices are designed to help providers understand the Medicare program and, ultimately, bill for their services correctly.

Costs for the PCC are primarily driven by the number of minutes of telephone service. Other costs include toll-free lines, support contracts, answering inquiries and customer service representatives.

In FY 2021, contractors are expected to respond to 19.6 million telephone inquiries and 500,000 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. In an effort to drive efficiency, Interactive Voice Response (IVR) systems are used to automate approximately more than 50 percent of their telephone inquiries. Increased

utilization of the IVR frees up customer service representatives to handle the more complex questions.

The following table displays provider toll-free line call volumes for FY 2018 – FY 2019 (actual) and FY 2020-2021 (estimated):

Provider Toll-Free Service Call Volume
(Call Volume in Millions)

	FY 2018 Actual	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate
Completed Calls	22.5	19.6	19.6	19.6

Provider Outreach and Education –The goal is to share up to date information on Medicare procedures and policies with Medicare providers to ensure appropriate billing and processing. The Medicare contractors are required to educate providers and their staff about the fundamentals of the program, policies and procedures, new initiatives, and significant changes including any of the more than 500 change requests that CMS issues each year.

Coordination of Benefits (COB) Contractor: $11.6 million. Coordination of Benefits activities include the collection and processing of coverage data from multiple sources. The data allows accurate claims processing, prevents Medicare from making incorrect payments, and helps identify debts to be recovered under the Medicare Secondary Payer (MSP) statute. The increase as compared to the FY 2020 Enacted level reflects additional workload due to mandatory prescription reporting per SUPPORT Act section 4002.

Ongoing Operations Support Activities: $16.7 million. The National Provider Education, Outreach, and Training initiative is responsible for the development of the Medicare Learning Network (MLN) Matters® articles and other education products for providers. Educational products/services are branded as part of the MLN and include MLN Matters® national articles, MLN publications (e.g., fact sheets, quick-reference charts, and booklets), web-based training courses, educational tools and podcasts. MACs and Regional Office (RO) staff are required to use MLN products to promote consistency in their outreach efforts which results in reduced costs associated with MACs and ROs developing their own materials. MLN products are commonly developed in response to recommendations in Office of the Inspector General (OIG) and Government Accountability Office (GAO) reports. Funding will support the development and dissemination of Medicare FFS educational information on Medicare policy and operations. This funding also supports fulfillment activities related to requests for hard copy products and other operational support to perform related outreach and education.

MAC Transition Cost: $7.9 million. Medicare contracting reform changed the face of the traditional Medicare program by integrating Parts A and B FFS claims contracting under a single contract authority, known as a MAC, using competitive acquisition procedures under the Federal Acquisition Regulation (FAR). CMS must support the transition, termination, and implementation costs associated with transitioning from incumbent MACs to their successor MACs. In FY 2021, CMS has scheduled the re-procurements of the A/B MAC

Jurisdiction JK and JL contracts. There are currently no DME MAC Jurisdiction contracts scheduled for re-compete in FY 2021.

Virtual Data Center Operations (VDC): $59.8 million. This funding request will continue to provide the infrastructure to all CMS Medicare Fee for Service Part A, B, and DME production operations. This funding also includes the CWF hosts previously performed by over 20 different legacy Medicare data centers, web hosting services for Medicare.gov, CMS.HHS.gov, CMSNet and the Health Plan Management System (HPMS), and Application Hosting services for the 1-800 Medicare Next Generation Desktop Data Warehouse, and the Provider Environment.

Fee-for-Service Operations and System Support

This account serves as the primary operations support center for the management of Medicare Parts A and B. These contracts support a myriad of critical functions centered on improving Part A and Part B FFS information, education, service initiatives, coverage and payment policies, health care quality, and general administrative and legislative actions. Many of these activities promote accountability, communication, coordination and aid the decision-making for programmatic and functional issues across the organization. These activities help to ensure the effective management of CMS' programs.

Budget Request: $74.6 Million

The FY 2021 President's Budget request for FFS operations support is $74.6 million, a decrease of $36.2 million below the FY 2020 Enacted Level. At this funding level, CMS will fund current Agency initiatives and several additional critical services supporting the Medicare FFS program. These include:

- *A-123 Internal Controls Assessment*: $2.0 million. The OMB Circular A-123 requires that CMS establish and maintain internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. The OMB Circular A-123 also requires the Administrator to submit a statement of assurance on internal controls over financial reporting. Funding supports a certified public accountant firm to conduct a rigorous assessment of the CMS internal controls over financial reporting. This assessment includes performing internal control reviews (formerly SAS 70 audits) for Title XVIII Medicare contractors.

- *Actuarial Services*: $1.2 million. This contract provides additional actuarial services, including modeling, for the numerous requests that the Office of the Actuary is unable to handle due to time constraints and staff shortages. This contract also assists CMS in providing actuarial cost estimates for various demonstrations and other statutorily required issues.

- *Payment Policy Development Support*: $1.7 million. CMS performs program monitoring and payment system analysis across Medicare programs to monitor the effects of program policy changes on healthcare utilization and outcomes for Medicare beneficiaries, investigate technical payment questions to support policy development and identify aberrant behavior to enhance payment integrity of the Medicare program. This request supports the ongoing analysis of claims data for potential refinements, ad hoc analysis, modeling payments and impacts that may result in policy changes to existing payment systems and support of regulatory development.

- *Cost Contract Audits*: $2.2 million. CMS has 179 contract awards with firms who have cost reimbursable contracts requiring necessary steady state audit efforts to comply with the FAR and Departmental Supplemental Regulations (HHSAR). The GAO and HHS OIG have identified CMS' lack of compliance with the FAR and HHSAR regarding mandatory audits and proper internal controls. This funding supports the effort needed to perform audits required by law during the contract acquisition life cycle to comply with FAR and HHSAR.

- *Home Health Prospective Payment System Refinement*: $1.3 million. Section 5012 of the 21st Century CURES Act introduces a new Medicare home infusion therapy benefit set to begin in 2021. Medicare will make a single payment for professional and nursing services, training and education, remote monitoring, and monitoring services for providing home infusion therapy and drugs. This funding will provide for contractor support to analyze data of the home infusion industry to evaluate the scope of the benefit and identify the best and most efficient way to develop the regulation.

- *IT Systems*: $8.0 million. CMS hosts many systems that aid in managing contracts for FFS and automate the change management process. This budget request continues funding operations and maintenance for Contractor Management Information System (CMIS), Enterprise Electronic Change Information Management Portal (eChimp) system, and the Common Electronic Data Interchange (CEDI).

- *Large Appeals Settlement Initiative*: $2.0 million. This request pays for effectuation activities performed by the MACs to support CMS' Large Appeals Support Settlement Contractor, which is responsible for ensuring that all appeals settlements are executed correctly. Appeals settlements result in the removal of settled appeals from the backlog pending at the Office of Medicare Hearings and Appeals. CMS estimated costs based on historical rates for this same function in past years.

- *Medicare Beneficiary Ombudsman*: $2.2 million. The legislative mandate for the creation of a Medicare Ombudsman (MMA Section 923) requires the Medicare Beneficiary Ombudsman to provide assistance to Medicare beneficiaries with handling their inquiries, complaints, grievances, appeals, and to provide recommendations for improvement in the administration of the Medicare program. This funding is for existing contract support for a wide variety of activities, including development of the Medicare Ombudsman annual report to the Secretary and to Congress.

- *Medicare Cures Act Support:* $1.3 million. The 21st Century Cures Act requires expanded use of telehealth technology and home infusion therapy for Medicare beneficiaries. CMS requires support to oversee the national implementation of new regulations promulgated under the Cures Act and contract support to aid in education and training, technical assistance, and an evaluation of the findings.

- *Medicare Healthcare Effectiveness Data and Information Set (HEDIS) Quality of Care Performance Measures*: $1.5 million. This funding provides for the proper oversight and management of Medicare Advantage organizations (MAOs) and Special Needs Plans (SNPs) quality performance by developing and improving specific HEDIS measures for MAOs and SNPs and reviewing and approving SNP Models of Care. CMS will work on developing and testing new quantifiable outcome measures that will

provide more specific information about Medicare Advantage plans' (including SNPs) ability to provide a high level of care coordination and its impact on enrollee health outcomes. This activity is critical for CMS to be able to evaluate SNPs' ability to effectively coordinate care for older and/or disabled adults and to develop tangible SNP models of care outcome measures.

- *Minority and Rural Health Initiatives:* $2.0 million. The CMS Rural Health Council was established to develop long-term solutions for health care challenges and access issues in rural America. The council developed a strategic plan to make health care in rural America more affordable, accessible, and accountable. The funding supports continued implementation and evaluation of the strategic initiatives supporting this initiative and minority specific healthcare interests.

- *Printing and Postage*: $16.4 million. This contract provides for the printing and postage costs associated with direct billing of Medicare Part A, Part B and Part D Income-Related Monthly Adjusted Amount premiums for beneficiaries who may not receive a monthly Social Security Administration, Office of Personnel Management, or Railroad Retirement Board benefit check from which the premiums are deducted and are not part of a State Buy-in Agreement or Formal Group Payer Arrangement. CMS is expecting the number of bills mailed to the direct billed beneficiary population to increase in FY 2021 resulting in increased ongoing FFS printing and postage needs. In addition, the number of beneficiaries choosing Medicare Easy Pay as their preferred payment method will continue to increase. Participants in Medicare Easy Pay receive 12 monthly statements versus beneficiaries who receive quarterly bills, resulting in higher printing and mailing costs.

- *Prototypic Shared Services:* $0.9 million. The funding is for ongoing operations and licensing costs to launch a single sign-on authorization through integration with CMS Enterprise Identify Management and Enterprise Portal (ePortal) shared services while utilizing the Salesforce platform.

- *Other Operational Costs:* $31.9 million. This request supports activities involving program monitoring, provider validation, satisfaction surveys, and many other FFS administrative functions. This funding level also supports Agency initiatives as directed by the Administration.

Claims Processing Systems

CMS' claims processing systems process nearly 1.3 billion Part A and Part B claims each year. The claims processing systems receive, verify, and log claims and adjustments, perform internal claim edits and claim validation edits, complete claims development and adjudications, maintain pricing and user files, and generate reports. The requested funding provides ongoing systems maintenance and operations.

Budget Request: $78.1 Million

The FY 2021 President's Budget request for claims processing systems is $78.1 million, an increase of $4.3 million above the FY 2020 Enacted level. In FY 2021, CMS will continue to implement recurring and non-recurring software changes and upgrades to the claims processing systems.

The main systems include:

- *Medicare Fee-For-Service Shared Systems:* Medicare Administrative Contractors (MACs) use standard systems to adjudicate Part A, Part B, and DME claims. All claims are sent to the Common Working File (CWF) for eligibility, duplication, and utilization checks before final adjudication.

- *Fiscal Intermediary Shared System (FISS):* is used to process more than 225 million Medicare Part A claims, including outpatient claims submitted under Part B.

- *Multi Carrier System (MCS):* is used to process over 1 billion Medicare Part B claims for physician and non-physician practitioner care and other non-DMEPOS Part B services (e.g., ambulance)

- *ViPS Medicare System (VMS):* is used to process claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

- *Common Working File (CWF):* The CWF system works with Medicare claims processing systems to ensure that:

    - The beneficiary is entitled to either Part A or Part B benefits, depending on the type of claim submitted;

    - The co-pay and/or deductible applied, if any, is accurate; and,

    - Medicare benefits are available for the services submitted on the claim for that beneficiary.

  The CWF system also ensures that the services on the claim have not been paid on another claim - either the same type or another type of claim to prevent duplicate payments.

- *Single Testing Contractor:* provides integration and regression testing for Medicare fee-for-service claims processing systems.

Multi Carrier Claims Processing System (MCS): $12.4 million. This funding will process Medicare Part B claims for physician care, durable medical equipment, and other outpatient services nationwide. MCS interfaces directly with the Healthcare Integrated General Ledger Accounting System (HIGLAS) to perform daily functions of payment calculation (following pre-payment validation), formatting, and accounting, thereby ensuring timely and accurate delivery of Medicare benefit payments.

Enrollment Database and Direct Billing Support: $9.4 million. This funding supports system development, maintenance and also FISMA compliance of the Medicare Enrollment and Premium Billing Systems (MEPBS).

CWF Program Maintenance: $4.7 million. This funding supports the operational support to ensure interaction with the Medicare claims processing systems.

Part A Processing System Maintenance & Implementation: $19.7 million. This funding will support Part A bills and interface directly with the Common Working File (CWF) system for

verification, validation, and payment authorization. This system also interfaces directly with the Healthcare Integrated General Ledger Accounting System (HIGLAS) to perform daily functions of payment calculation (following pre-payment validation), formatting, and accounting, thereby ensuring timely and accurate delivery of Medicare benefit payments.

Durable Medical Equipment MAC Claims Processing Systems: $16.1 million. This funding supports DME functionality for claims collection, editing, pricing, adjudication, correspondence, on-line inquiry, file maintenance, financial processing and reporting.

Other Claims Processing Systems: $15.6 million. This funding supports core requirements for processing claims. This include data collection and validation, claims control, pricing, adjudication, correspondence, on-line inquiry, file maintenance, reimbursement, and financial processing.

DME Competitive Bidding

Section 302(b)(1) of the Medicare Modernization Act (MMA) authorized the establishment of a new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) acquisition program which replaces the current Medicare Part B fee schedule payment amounts for selected items in certain areas with payment amounts based on competitive bidding. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in ten metropolitan statistical areas (MSAs) in 2007. The Medicare Improvements for Patients and Providers Act (MIPPA) and the Affordable Care Act (ACA) subsequently amended and expanded the program to cover 100 MSAs. ACA also mandated that all areas of the country be subject to either DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The program sets appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Budget Request: $82.1 Million

The FY 2021 President's Budget request for DME competitive bidding is $82.1 million, an increase of $55.3 million above the FY 2020 Enacted level. CMS is currently preparing for the next round of the DMEPOS Competitive Bidding Program to be implemented on January 1, 2021. The requested funding will allow CMS to hire an implementation contractor and make enhancements to the DME bidding System.

- *Competitive Bidding Implementation Contractor (CBIC):* $79.8 million. The FY 2021 budget request represents the estimated need for preparation activities, such as outreach and education, bidding activities to include evaluation, inquiry review, and supplier contract award process, operations and maintenance, and also the CBIC secure portal and technical help desk for round 2021 bidding.

- *DME Bidding Systems (DBidS)*: $2.2 million. CMS will invest in mitigating end-of-life software, addressing aging technologies, and adapting to policy changes and transitions. Transition requirements include development, enhancements, and operations and maintenance.

II. OTHER MEDICARE OPERATIONAL COSTS

Program Description and Accomplishments

Accounting and Audits

The Healthcare Integrated General Ledger Accounting System (HIGLAS) is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting functions for all of CMS' programs. It reduced 50 separate accounting/payment systems for Medicare and Medicaid into one system. The main objective of this effort was to increase automation and efficiency, while eliminating redundant and inefficient/ineffective manual processes. HIGLAS is a component of the Department of Health and Human Services (HHS) Unified Financial Management System (UFMS), and CMS continues to closely coordinate efforts with HHS to ensure HIGLAS core financial data integration with UFMS. The unification of the financial systems is aimed at improving data consolidation and financial reporting capabilities for all of HHS.

Budget Request: $94.6 Million

The FY 2021 President's Budget request for HIGLAS and the CFO audit is $94.6 million, a decrease of $8.8 million below the FY 2020 Enacted level. In FY 2021, the decrease in need can be attributed to operational efficiencies by establishing cost saving reductions in production and application maintenance of HIGLAS.

- *HIGLAS*: $83.2 million. This funding supports operations and maintenance costs for HIGLAS. HIGLAS implementation strengthened the federal government's fiscal management and program operations of the Medicare program. HIGLAS was a critical success factor in CMS and HHS achieving compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. In addition, HIGLAS contributes towards HHS' ability to retain a "clean" audit opinion as required by the Chief Financial Officer's (CFO) Act.

  HIGLAS is a mission critical application enabling CMS to manage program accounting for its business operations. It is the largest Oracle Federal Financial System based on the 4.5 million transactional claim records and the payments equating to over $1.4 trillion in gross outlays in FY 2018 alone. HIGLAS continues to enhance CMS' oversight of all financial operations in order to achieve reliable, auditable, timely financial accounting, and reporting for all of CMS' programs and activities.

  The HIGLAS effort has improved significantly the ability of CMS/HHS to perform Medicare accounting transactions. Some of these improvements include reduced costs due to elimination of redundant individual Medicare financial record systems, improvements in automated Medicare debt collection/referral activities, creation of audit trails for every Medicare transaction/payment/claim in HIGLAS, improved Medicare financial audit ability, and improved capability for CMS to more systematically and efficiently recover identified Medicare overpayments. Moreover, CMS now has better internal financial controls across Medicare contractor operations. Maintaining a state-of-the-art financial system like HIGLAS has a significant and positive impact on the amount of additional interest earned (saved) in the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than in a pre-HIGLAS environment. This is a direct result of

efficiencies gained in the process of offsetting or "netting" receivables that are owed by Medicare providers to the government. In addition, HIGLAS supports the Federal Payment Levy Program (FPLP) operated by Treasury by offsetting payments. Through January 18, 2019, CMS has recouped $651.58 million in federal tax debts and $284.87 million in nontax debts from Medicare Provider Payments under the FPLP.

- *CFO/Financial Statement Audits:* $11.4 million. This funding is necessary for the statutorily required CFO audit which ensures CMS financial statements are reasonable, internal controls are adequate, and CMS complies with laws and regulations. The cost of the audit is funded through an interagency agreement between CMS and HHS and is based upon the General Services Administration rate schedules and federal audit requirements.

  CMS is required under OMB Bulletin A-136 to prepare annual and quarterly financial statements. The yearly CMS financial statements must be audited annually in accordance with the Government Management Reform Act of 1994 and OMB Bulletin No. 07-04. CMS' goal is to maintain an unmodified audit opinion, which indicates that our financial statements present fairly in all material respects, the financial position, net costs, social insurance, changes in net position, budgetary resources, and financing of CMS.

Qualified Independent Contractor Appeals (QIC)

Section 521 of the Benefits Improvement and Protection Act of 2000 (BIPA) requires CMS to contract with Qualified independent contractors (QICs) to adjudicate second level appeals resulting from an adverse redetermination of a claim by a MAC during the first level of appeal. BIPA requires that QICs process Medicare Parts A and B claim appeals within 60 calendar days of receipt. If a QIC is unable to complete the appeal within the 60 day timeframe, then it must notify the appellant that it cannot timely complete the appeal and offer the appellant an opportunity to escalate the appeal to an Administrative Law Judge at the Office of Medicare Hearings and Appeals (OMHA). This program ensures that Medicare beneficiaries' providers have the opportunity to continue seeking payment for services in the event of an initial adverse claim determination and is essential to maintain provider participation in Medicare.

Budget Request: $77.8 Million

The FY 2021 President's Budget request for QIC appeals (BIPA section 521) is $77.8 million, an increase of $0.4 million above the FY 2020 Enacted level. The request funds a minimal growth in workloads and maintains steady state operations.

- *QIC Operations*: $67.4 million. This request includes annual operational costs and activities to advance the Departmental priority of continuing to timely adjudicate Medicare appeals at the second level in the appeals process.

The table below includes a breakout of the reconsiderations workload from FY 2018 – 2019 (actuals) and FY 2020 – FY 2021 (estimated). The FY 2020 through FY 2021 projections were formulated based upon FFS enrollment growth projections from CMS Office of Actuary. As in previous years, CMS will continue to review and analyze workload trends and adjust as necessary.

QIC Appeals Workload
(Volume in Claims)

	FY 2018 Actual	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate
Non-RAC QIC Claims	683,127	525,399	532,263	544,574
% Increase from Previous Year	-18.05%	-23.01%	3.06%	2.26%

The following chart details the percentage of appeals completed timely by type from FY 2016 through FY 2019 to date:

Fiscal Year	Reconsiderations (2nd Level of Appeal)	
	Part A	Part B
2016	96.73%	99.72%
2017	92.74%	99.68%
2018	92.71%	99.61%
2019	99.90%	99.72%

In furtherance of the Departmental priority to improve the Medicare appeals process and address the pending backlog of appeals at Levels 3 and 4, CMS initiated several administrative actions that may have contributed to the decrease in claims following several years of substantial growth. These initiatives include, but are not limited to, the following:

- QIC Discussion Demonstration: In January 2016, CMS launched a demonstration with durable medical equipment suppliers that allows the suppliers the opportunity to discuss their denied claim with the QIC. In addition to the discussion, the appellant has the opportunity to submit additional documentation to support their claim and receive feedback and education on CMS policies and requirements. The Demonstration also gives suppliers the opportunity to have claims currently pending at OMHA reopened and resolved favorably.

  On November 1, 2018, CMS expanded the Demonstration to include DME suppliers within DME MAC jurisdictions A and B, for all claim types, except claims for glucose/diabetic testing strip supplies. As of January 2019, the QIC conducted more than 134,000 discussions and the favorability rate on reconsiderations issued after a discussion was approximately 63 percent (includes fully and partially favorable decisions).

Under this Demonstration, the QIC also has the authority to conduct reopenings on previously adjudicated unfavorable claims that are currently pending ALJ assignment at OMHA, and/or unfavorable reconsiderations that have been decided by the QIC, but not yet appealed to OMHA. As of January 2019, the QIC reopened and resolved favorably more than 95,000 claims previously pending in the OMHA backlog. In addition, the QIC worked with suppliers to submit withdrawals to OMHA on more than 152,000 claims. As of April 2019, the demonstration's expansion includes Part A claim types.

The QIC discussion demonstration concludes at the end of 2020. The Budget does not include separate funding to continue operations of the demonstration. CMS may choose to continue these activities within discretionary Program Management.

- Settlement Facilitation Conferences: OMHA staff who have been trained in mediation techniques are facilitating settlement conferences between CMS and appellants. These conferences bring appellants and CMS together to discuss administratively settling pending appeals at Levels 3 and 4. Beginning in April 2018, OMHA expanded the Settlement Conference Facilitation program to reach additional appellants. Appellants not eligible for the Low Volume Appeals Settlement and other Medicare appeals administrative activities can be eligible to participate in this alternative dispute resolution process for their pending appeals.

- Low Volume Appeal Initiative: As of November 3, 2017, appellants with fewer than 500 appeals pending at Levels 3 and 4, combined, are eligible to settle the portion of their pending appeals that have total billed amounts of $9,000 or less per appeal in exchange for timely partial payment of 62 percent of the net Medicare approved amount.

- *Medicare Appeals System (MAS)*: $10.4 million. An important part of the BIPA reforms was the creation of the Medicare Appeals System (MAS). MAS' goal is to support the appeals process for the FFS, Medicare Advantage, and Prescription Drug Programs. MAS is a system that tracks and records Medicare appeals through multiple levels of the appeal process. The system leverages processes and consolidates data to allow users across appeal levels to realize benefits of reusable, centralized data. The system supports standard processing of appeals and availability of data to other appeal levels while allowing stakeholders and user groups to shape procedures at their desired level. CMS maintains the system and implements all necessary system changes.

HIPAA Administrative Simplification

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Secretary of HHS to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data. As the industry adopts these standards for the efficiency and effectiveness of the nation's health care system, it will improve the use of electronic data interchange which serves as one of CMS' long standing goals for the nation's healthcare.

Budget Request: $22.2 Million

The FY 2021 President's Budget request for HIPAA Administrative Simplification is $22.2 million, a decrease of $16.1 million below the FY 2020 Enacted level. At this funding level, CMS will maintain base operations. Funding is requested for the following activities:

- *HIPAA Claims-Based Transactions and Electronic Data Interchange (EDI)*: $10.0 million. The Medicare program responds to electronic requests for eligibility information from providers and health care institutions using the adopted standard. CMS built the Health Eligibility Transaction System which provides eligibility information to FFS providers to assist them with properly billing for the services they provide to Medicare beneficiaries and in the processing of Medicare claims. This systems application is considered mission critical as it provides eligibility information on a real-time basis as well as assists in determining how Medicare should be billed for the services rendered. The request will support the maintenance and operation of this eligibility system as well as allow CMS to be in compliance with the HIPAA EDI standard.

- *NPI and NPPES*: $7.2 million. HIPAA requires the assignment of a unique National Provider Identifier (NPI) to all covered health care providers and non-covered health care providers who apply and are eligible for NPIs. This project covers the operational support for issuing NPIs, a national customer service call center to assist providers in obtaining their NPI, and operational costs for the National Plan and Provider Enumeration System (NPPES) system. CMS built NPPES to assign NPIs and process NPI applications. Currently, over 5 million NPIs have been assigned and over 4.9 million changes have been applied to the NPPES records of enumerated providers. In FY 2021, functionality is being expanded to send new NPIs to the Automated Provider Screening (APS) system in order to screen providers for identity, licensure, and criminal checks before they apply for Medicare Enrollment in the Provider Enrollment Chain Ownership System (PECOS), as well as sending provider identifications to the Data Exchange System (DEX) for Medicaid.

- *HIPAA Administrative Simplification Enumeration and Audit of Health Plans*: $0.9 million. CMS is responsible for driving the enumeration of health plans as required by HIPAA and estimates that as many as 130,000 health plans may need to be enumerated. Contractor support is needed to assist health plans with the enumeration process, responding to questions, inquiries, complaints or requests for assistance or record maintenance. As new standards are adopted, health plans will need continued support with enumeration.

- *HIPAA Enforcement*: $4.1 million. CMS manages the administrative simplification enforcement and certification provisions of HIPAA which includes the complete suite of case management services for complaints, managing the certification of compliance process, and monitoring compliance with corrective action plans. CMS will continue conducting industry compliance reviews and audits, which will enhance existing tools to collect and analyze data, and disseminate information.

Research, Demonstration, and Evaluation (RDE)

This program supports CMS' key role as a beneficiary centered purchaser of high-quality health care at reasonable costs. CMS develops, implements, and evaluates a variety of research and demonstration projects. These projects, in addition to data and information products, were created to support internal and external research, and continue to inform and guide CMS' efforts to improve the efficiency of payment, delivery, access, and quality of our health care programs. CMS leverages other funding sources, such as ACA 3021 (Innovation Center) funding, to support RDE projects wherever possible.

Budget Request: $16.7 Million

The FY 2021 President's Budget request for RDE is $16.7 million, a decrease of $3.4 million below the FY 2020 Enacted level. CMS will continue funding ongoing research data analytic activities supporting CMS and split-funding the Medicare Current Beneficiary Survey (MCBS) with the Innovation Center. This request represents ongoing maintenance and operations.

- *Medicare Current Beneficiary Survey (MCBS)*: $12.7 million. This funding maintains the survey's content and utility, and supports statutory requirements. In FY 2021, CMS plans to continue an equal split of the MCBS' total operational cost of $25.4 million between RDE and the Innovation Center at $12.7 million each.

  The MCBS is an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of the MCBS are enhanced with CMS administrative data (e.g. fee-for-service claims, prescription drug event data, enrollment, etc.) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 20 years (encompassing over 1 million interviews) and consists of three annual interviews per survey participant.

- *Chronic Condition Warehouse (CCW):* $0.8 million. CMS is required to comply with Section 723 of the MMA to provide a database to support chronically ill Medicare beneficiaries. The CCW houses a large amount of data and serves as an important resource for both internal and external researchers. Researchers accessing the data in the CCW are performing research to identify ways to improve the quality of care and ensure cost effective care for chronically ill Medicare beneficiaries. These research projects evaluate possible changes in or alternatives to the current Medicare and Medicaid programs that can lead to improvements in patient outcomes. The funding request supports maintaining data sources and research and public use files, ad hoc requests, loading future data sources, and the creation of new research files.

- *Other Research:* $3.2 million. This funding supports efforts that build and improve CMS' health service research, data, and analytical capacity, as well as program evaluations. These activities include the Research Data Assistance Center (ResDAC), Public Use Data Files, Medicaid Analytic Data, Historically Black Colleges and Universities, and Hispanic-Serving Institutions Research Grant Programs.

III. MEDICAID AND CHIP

Program Description and Accomplishments

Medicaid and Children's Health Insurance Program (CHIP) Operations

CMS serves as the operational and policy center for the formulation, coordination and evaluation of all national program policies and operations relating to Medicaid and the Children's Health Insurance Program (CHIP). Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the states. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally enacted to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children program, while the Supplemental Security Income program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a large population of low-income adults and families, pregnant women, people of all ages with disabilities, and people who require long-term care services. CHIP is a federal-state matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. Medicaid and CHIP enrollment is expected to be 80.6 million in FY 2021 with more than 1 in 5 Americans enrolled in Medicaid or CHIP.

Budget Request: $126.3 Million

The FY 2021 President's Budget request for Medicaid and CHIP operations is $126.3 million, a decrease of $20.2 million below the FY 2020 Enacted level. This funding supports administrative activities necessary to effectively operate and improve oversight of Medicaid and CHIP programs. This will allow CMS to reinvent Medicaid operations through improving data systems, and continuing support for the Medicaid and CHIP (MAC) scorecard that will increase transparency and accountability to allow states to better serve the interests of their citizens.

- *The National Home and Community-Based Services (HCBS) Quality Enterprise*: $4.2 million. The Home and Community-Based (HCB) settings activity assists CMS in reviewing and monitoring Statewide Transition Plans (Plans) designed to bring states into compliance with the HCB settings requirements, to ensure HCB settings are integrated, and individuals receiving Medicaid HCBS have equal access to community support. The Administration has given states additional time to come into compliance with the 2014 HCBS final rule; states must now be in compliance by March, 2022. The Home and Community-Based Services Technical Assistance activity provides states with individual goal assessment, technical assistance, tools and information to help states determine, prior to the implementation of Medicaid program structures, policies and procedures, the best authority that will meet the states' needs and the needs of the individuals the states wish to serve. CMS and ACL have also launched a joint funding opportunity for the National Center on Advancing Person-Centered Practices and Systems (NCAPPS). NCAPPS will provide training, an information clearinghouse, and in-depth technical assistance to states, territories, and tribes to transform their long-term care service and support systems to implement HHS' policy on person-centered thinking, planning, and practices. Funding also supports the HCBS measure development and maintenance, which also supports the availability of HCBS quality

measures and data for use in other CMS initiatives, including the Medicaid and CHIP Scorecard and the Adult and Child Core Sets.

- *Learning Collaborative:* $2.1 million. These are forums for facilitating consultation between CMS and states with the goal of designing the programs, tools and systems needed to ensure that high-performing state health insurance programs are in place and are equipped to handle the fundamental changes brought about by legislation. The learning collaborative process enables participants to identify gaps in knowledge and technical skills, engage existing subject matter authorities to help address the challenges associated with implementing program changes, and create a supportive environment that encourages the adoption of promising practices and problem-solving strategies.

- *Medicaid and CHIP Business Information Solution (MACBIS):* $42.9 million. MACBIS is a CMS enterprise-wide initiative to improve the data infrastructure and information technologies that support Medicaid and CHIP. CMS is working with states and both internal and external stakeholders to improve Medicaid and CHIP data and data analytic capacity through MACBIS. MACBIS upgrades are needed and will be used by a variety of Medicaid programs and mandates. These costs are borne by a variety of accounts in addition to Program Operations. With the contributions from those other accounts, this request fully funds the four major information technology upgrades under MACBIS. First, the request supports ongoing operations and maintenance of the Transformed Medicaid Statistical Information System (TMSIS), developing public use files and releasing TMSIS data to states and other stakeholders. Both GAO and the HHS OIG have identified completion of TMSIS as a top priority for the Medicaid program. Second, the request supports continued work on the Medicaid drug rebate system rebuild, which is critical to adequate oversight of the Medicaid drug rebate program. Third, the request supports continued work to replace the aging Medicaid financial system that tracks state financial reporting and administrative spending. Finally, the request will support the rollout of additional authorities in the Medicaid and CHIP Program (MACPro) system, which is a state-facing portal to capture states' submissions of state plan amendments, waivers, quality measures, advanced planning documents, and other documents. These MACBIS systems will give users improved access to data quality tools for analysis and evaluation for more informed decision making; allow for easier identification of priority, missing, and anomalous data; and enhance internal and external program monitoring and oversight.

- *Managed Care Review and Oversight*: $0.7 million. Managed care is the dominant delivery system for Medicaid benefits. As of 2017, over $297 billion dollars were spent annually on Medicaid managed care. Currently, there are 48 states and the District of Columbia operating over 170 programs covering roughly 65 million individuals. CMS implemented this activity to increase its oversight and technical assistance to states to address the needs created by the growth of managed care and GAO concerns. Under this activity, CMS created guidance for Managed Long Term Services and Supports and encounter data. CMS also produced the 2013 - 2017 Medicaid Managed Care Enrollment Report which provides managed care enrollment information. The FY 2021 request will support CMS efforts to implement the Medicaid and CHIP Managed Care Final Rule requirements including development of a comprehensive monitoring and oversight plan, provide requested technical assistance to states, and update internal monitoring tools for CMS.

- *Medicaid and CHIP (MAC) Scorecard Initiative:* $32.0 million. This initiative is designed to provide increased transparency about program administration and outcomes and to assist states and CMS in aligning efforts to drive improvements and increase accountability. The MAC Scorecard, released in June 2018, included measures voluntarily reported by states, as well as federally reported measures in three areas: state health system performance; state administrative accountability; and federal administrative accountability. After the successful completion of the first MAC Scorecard in June 2018, CMS released additional versions of the 2019 MAC Scorecard in July 2019 and November 2019. The next MAC Scorecard release is scheduled for November 2020 and annually thereafter. CMS continues to develop more robust data interaction and increased web functionality with the goal of releasing an annual MAC Scorecard that more closely aligns with the annual Child and Adult Core Set measures publishing cycle. CMS also plans to develop and add additional quality measures to the MAC Scorecard, leveraging TMSIS analytic data to identify and provide additional measures. The FY 2021 budget request supports states in data driven, innovative approaches to improving quality, accessibility and affordability of care for adults to support gap areas identified in the Adult Core Set measures. The use of quality measurement supports state accountability for program performance at provider, clinic/practice, community, health plan, and state-wide levels. These costs are borne by a variety of accounts in addition to Program Operations. In addition to Program Management funding, CMS will also rely on ACA Section 2701 funding to support the Adult Health Quality Measures being reported through this Scorecard initiative.

- *State Demonstration Evaluations:* $5.9 million. Contractor support is required to conduct federal evaluations through meta-analyses of selected types of Medicaid Section 1115 demonstrations including, community engagement strategies and comprehensive treatment strategies for substance use disorder. The primary sources of information to conduct these analyses will be data reported by states in the monitoring and evaluation reports. The data and reports include performance on quality and other program performance metrics, including Medicaid Adult and Child Core Metrics, implementation costs, regular quarterly and annual monitoring reports, and state interim and summative evaluations. This includes a survey of beneficiary experience with these specific waivers. The contractor will review federal national survey data and state claims and encounter data to compare, among other things, beneficiary participation, continuity of coverage, access to care, and health outcomes. In FY 2019, a State Medicaid Director Letter on treatment improvements for Serious Mental Illness was released and CMS expects these improvements to be taken up by the majority of states. FY 2021 funding will be used to continue existing efforts, and conduct meta-analysis to understand policy impacts to support diffusion of best practices for Serious Mental Illness.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency*: $8.5 million. Section 1115 of the Social Security Act provides broad authority to CMS and states under Medicaid and CHIP to design, implement and test new approaches to coverage, payment and service delivery, with the intention of improving whether and how low-income people receive health care, the quality and outcomes of that care, and its cost to the federal government and to states. Currently 42 states operate at least one demonstration under an 1115 waiver, and a growing number of states operate most or all of their Medicaid program under section 1115 authority. FY 2021 funding will aid in conducting front-end assessments of 1115 demonstration designs, oversight and management of post-approval state deliverables, and increased technical support that

states need to adequately conduct monitoring and evaluation of new types of 1115 demonstrations such as the innovation in program financing.

- *Survey of Retail Prices*: $8.8 million. The Survey of Retail Prices initiative involves a pharmacy survey to aid states in efficiently reimbursing pharmacies for prescription drugs. The purpose of this project is to perform a monthly nationwide survey of retail community pharmacy invoice drug prices and to provide states with on-going pricing files. The resulting prices derived from this survey have been developed into the National Average Drug Acquisition Cost (NADAC). The NADAC files are posted on Medicaid.gov and are updated weekly. These files provide state Medicaid agencies with an array of covered outpatient drug prices concerning acquisition costs for covered outpatient drugs. The state agencies have begun to implement the NADAC as their approved State Plan reimbursement methodology. In addition, Value Based Purchasing expertise is needed to assist state Medicaid programs to design and implement new value based purchasing programs and new payment models for drugs. The FY 2021 request supports the renewal of the contract to meet this statutory requirement and for Value Based Purchasing.

- *Other Medicaid, CHIP, and Basic Health Program Activities*: $21.2 million. CMS has a variety of operational contracts supporting Medicaid and CHIP. These activities provide support for Connecting Kids to Coverage grants, Medicaid Access regulation support, analytics support, systems support, and evaluations and technical assistance for Medicaid related programs. Additionally, Section 12006(a) of the 21st Century Cures Act requires an ongoing electronic visit verification system (EVS) to monitor all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider, and an ongoing, graduated, Federal Medical Assistance Percentage (FMAP) reduction for states that are not fully compliant. Section 12006(b) requires the collection and dissemination of best practices to state Medicaid directors. EVS tasks include surveying states, tracking/analyzing EVS findings, and conducting training for CMS and states related to EVS in order to share promising practices and promote compliance with guidance/policy. In FY 2019, CMS began allocating funding to the Sources of Income for Medicaid Eligibility Determination activity, which allows states to use the HUB to identify current sources of income (CSI) to determine eligibility. The access and availability of this CSI service is attractive to states because states can use the CSI service in lieu of their own direct contracts.

IV. HEALTH CARE PLANNING AND OVERSIGHT

Program Description and Accomplishments

CMS administers and oversees private health plans including Medicare Advantage (MA) (Part C) and Medicare prescription drug benefit (Part D) programs as well as private insurance market reform and oversight activities.

The following material describes the systems, management, and review activities needed to run these programs.

Part C and D Information Technology (IT) Systems Investments

CMS maintains several major systems needed to run the Parts C and D programs. These systems include:

- *Medicare Advantage Prescription Drug Payment System (MARx)* – This system supports the Medicare Modernization Act (MMA) Title I and Title II requirements for beneficiary enrollment and calculation of payments. The MARx also supports the Premium Withhold System.

- *Medicare Beneficiary Database Suite of Services (MBDSS)* – This contains beneficiary demographic and entitlement information. The MBDSS stores Low-Income Subsidy (LIS) beneficiary status. It also derives Part D eligibility periods, processes state files for the State Phase Down Billing System and deeming process, deems beneficiaries eligible for LIS, and assigns LIS beneficiaries to a Part D drug plan.

- *Drug Data Processing System (DDPS)* – This system collects the prescription drug event (PDE) data for each Medicare Part D claim and is used to generate invoices to prescription drug manufacturers for the coverage gap discount program (CGDP).

- *Payment Reconciliation System (PRS)* – This system takes prospective payment data from MARx, the PDEs from DDPS, and direct and indirect remuneration (DIR) reports from the Health Plan Management System (HPMS) to calculate final reconciliation payments for Part D sponsors.

- *Integrated Data Repository (IDR)* – The IDR stores data from multiple CMS systems and programs for analytic and operational purposes.

- *Retiree Drug Subsidy System* – This system collects sponsor applications, drug cost data, and retiree data, and processes this information in order to pay retiree drug subsidies to plan sponsors. This system supports drug plan sponsors' participation in the Retiree Drug System program through data center hosting, hardware/software maintenance, system technical support, data/database administration, and system security testing.

- *Risk Adjustment System* – This system uses demographic and diagnostic data to produce risk adjustment factors to support payments to Medicare Advantage and Part D plans.

Budget Request: $29.8 Million

The FY 2021 President's Budget request for Parts C and D IT Systems Investments is $29.8 million, a decrease of $9.4 million below the FY 2020 Enacted level. The decrease in funding can be attributed to implementation cost savings in FY 2020 from migrating the Risk Adjustment Suite of Systems (RASS) to the cloud environment. The request also validates Parts C and D IT systems services contracts, which supports the daily business activities, business deliveries, and ongoing operational enhancements for a variety of systems. These activities include data center hosting, hardware/software maintenance, system technical support, database administration, and system security testing.

- *MA/Part D Help desk:* $3.6 million. This funding supports enrollment-related beneficiary requests applications.

- *Prescription Drug Event (PDE) Support:* $8.0 million. This funding supports system development, maintenance of the PDE record containing prescription drug cost and payment data.

- *Retiree Drug Subsidy Program*: $6.5 million. This funding supports data center hosting, hardware/software maintenance and software licenses related to the RDS program.

- *Other C & D IT*: $11.7 million. This funding supports the Part D Coverage Gap Discount Program, Risk Adjustment Suite of Systems, and Testing for Certification, Accreditation, Corrective Action and collaborative systems for sharing Part C & D data.

Oversight and Management of Health Plans

CMS oversees health insurance companies that offer health care coverage through private plans. Oversight and management activities needed to run the Part C, Part D, and private insurance programs include obtaining actuarial estimates, reviewing bids from the prescription drug and Medicare Advantage plans, approving new plan applicants for the new contract year, reviewing formularies and benefits, monitoring current plan performance, reconciling prior year plan payments, and expanding and supporting Part D enrollment of low-income beneficiaries. CMS funds activities to improve coordination between the federal government and states to enhance access to quality services for individuals dually eligible for both Medicare and Medicaid benefits, and helps states innovate using data-driven insights to better serve these individuals. These activities are vital to ensuring that beneficiaries are receiving the health care services that they expect from our programs.

Budget Request: $55.6 Million

The FY 2021 budget request for Oversight and Management is $55.6 million, a decrease of $30.3 million below the FY 2020 Enacted level. Beginning in FY 2020, CMS may need to support the CO-OP program through Program Management discretionary resources if the program does not receive mandatory funding. This FY 2021 funding level does not include administrative funding for the CO-OP program. CMS will maintain ongoing operations at the request level.

- *Medicare Parts C and D*: $45.5 million. This funding supports audits, actuarial reviews, estimates of Medicare Advantage and Prescription Drug Plans, the Retiree Drug Subsidy Program, and the on-going Medicare Part C and Part D reconsideration contracts. This also funds ongoing initiatives such as closing the Medicare Part D coverage gap, reforming Medicare Advantage plan payments, and making improvements to Part D plan operations.

Oversight and management also includes Part C and Part D appeal reviews. CMS contracts with an independent reviewer to conduct reconsiderations of adverse Medicare Advantage plan determinations, late enrollment penalties (LEP), and coverage denials made by Medicare Advantage and Part D plans. This review stage represents the second level of appeal for the beneficiaries in these plans. All second level reviews are done by the Qualified Independent Contractors (QICs).

The Parts C and D appeals workload history and projection is presented below:

QIC Appeals Workload for Parts C/D
(Volume in Appeals)

	FY 2018 Actual	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate
Part C Appeals	82,179	98,637	114,000	130,000
Part D Benefit Appeals	28,090	37,417	39,000	40,000
Part D LEP appeals	41,388	44,836	45,000	46,000

- *Insurance Market Reforms:* $2.4 million. CMS, on behalf of HHS, is required to enforce market wide protections under the Affordable Care Act. To ensure compliance, CMS collects and reviews plan documents from health insurance issuers and conducts investigations and market conduct examinations of non-federal government plans based on complaints received. Funds will be used to continue compliance with market wide requirements, to assist with research to investigate complaints, and to perform market conduct examinations.

- *Medical Loss Ratio (MLR):* $1.0 million. Section 2718 of the Affordable Care Act requires an issuer to publicly report annually how it used its premium revenue for the prior calendar year. This ensures that consumers receive value for their premium by requiring that plans use enrollees' premium dollars on medical care, quality improvement activities, or to pay rebates to policyholders. This data analysis ensures consumers receive the rebates they are entitled to if their health insurance issuer fails to meet the 80 percent (in the individual and small group market) or 85 percent (in the large group market) MLR standard. Based on continuing demand and to encourage states to take over enforcement activities, CMS will continue to develop training resources and provide technical assistance to States in conducting their own MLR examinations.

- *Rate Review:* $1.7 million. This request allows CMS to perform statutorily required duties to monitor and review rate submissions from health insurance plans. Rate increases higher than 15 percent must be reviewed and approved by either CMS or the relevant State Department of Insurance. CMS also publicly posts all rate changes on the agency's website in order to increase transparency.

- *Federal Coverage and Payment Coordination:* $5.1 million. Federal Coverage and Payment Coordination funds necessary activities and resources to implement the Medicare-Medicaid Coordination Office's (MMCO's) statutory obligations, as well as the HHS and CMS strategic goals. Each activity is pivotal in CMS' success in improving quality, cost, and care coordination for dually eligible beneficiaries. This work includes navigating a number of very complex operational issues, merging often conflicting systems, policies, financing, monitoring and oversight protocols, and data requirements across Medicare and Medicaid, and then adapting that work to the unique environment of each state.

Exchanges

The FY 2021 Budget includes a General Provision that would allow user fees collected in FY 2021 for the purpose of operating FFEs and Federal platforms leveraged by State Based Exchanges to be made available for any Federal administrative expenses the Secretary incurs for activities related to the Federal Exchange, including those activities that CMS conducts on behalf of all Exchanges. For additional information, please refer to the Federal Exchanges section of this FY 2021 Congressional Justification.

Budget Request: $0.0 Million

The FY 2021 President's Budget request for the Exchanges is $0.0 million, a decrease of $268.9 million below the FY 2020 Enacted level.

V. HEALTH CARE QUALITY

Program Description and Accomplishments

Health Care Quality

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through health care quality initiatives, such as the Medicare Shared Savings Program (MSSP). Value-based programs such as this not only help our beneficiaries receive high quality of care, but also create a more efficient and better healthcare service experience.

Budget Request: $67.0 Million

The FY 2021 President's Budget request for health care quality improvements is $67.0 million, an increase of $19.2 million above the FY 2020 Enacted level. In FY 2021, the additional funding will support MSSP. CMS is re-competing the ACO Program Analysis contract and must implement recent policy and program enhancements finalized in the Pathways to Success November and December 2018 final rules.

- *Medicare Shared Savings Program (MSSP)*: $58.0 million. The Medicare Shared Savings Program was implemented in January 2012 to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). Over 10.4 million Medicare fee-for-service beneficiaries receive care from providers participating in ACOs. Physicians continue to join ACOs each year, demonstrating that clinicians are recognizing the value and opportunity of coordinated care, quality improvement, and shared savings. In December 2018, CMS issued a Final Rule known as the 'Pathways to Success' that redesigns the program providing a quicker transition to performance based risk, promotes flexibility for ACOs to innovate, encourages low revenue ACOs to promote competition, ensures rigorous and accurate benchmarks, strengthens program integrity, and reduces burden. In FY 2021, CMS will continue implementation of this new rule, which will require redesigning support infrastructure including IT systems and program specifications.

- *Medicare Data for Performance Measurement:* $2.0 million. The Secretary is required to establish a process to certify qualified entities who will combine standardized extracts of Medicare Parts A, B, and D claims data with other sources of claims data to evaluate and report on the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. The funding requested will support contracts for program management, data preparation and distribution, and technical assistance.

- *Hospital Value-Based Purchasing (VBP):* $1.3 million. The Hospital Value-Based Purchasing Program was mandated by the Affordable Care Act and provides value-based incentive payments to hospitals based on their performance on quality and cost measures. FY 2021 funding is required to continue payment standardization of Medicare Part A and B claims on a monthly basis. CMS is working toward greater automation of this process, through integration into the shared systems, to support the calculation of resource use measures for VBP programs, and for other agency and external users who leverage this data for their work.

- *Other Health Care Quality Initiatives:* $5.7 million. The request includes funding to support the Hospital Readmission Reduction Program. This provision of the ACA requires the Secretary to make readmission rates for hospitals publicly available and directs the Secretary to establish a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations. Funding is needed so CMS can calculate hospital-specific readmission rates, calculate the hospital-specific payment adjustment factor for excess readmissions, and engage in rulemaking in order to maintain the current measures. This request also includes funding for Appropriate Use Criteria for Advanced Imaging Services, a program established by the Protecting Access to Medicare Act (PAMA) of 2014. In order to implement this program effectively, CMS focuses appropriate use criteria on clinical areas and imaging modalities with high Medicare volume.

VI. OUTREACH AND EDUCATION

Program Description and Accomplishments

National Medicare Education Program (NMEP)

The National Medicare Education Program (NMEP) was established to implement provisions of the Balanced Budget Act of 1997 and continues under the MMA of 2003. The program is comprised of five major activities including: beneficiary materials, the beneficiary contact center (1-800-MEDICARE), internet services, community-based outreach, and program support services.

NMEP is CMS' primary vehicle to educate Medicare beneficiaries and their caregivers so they can make informed health care decisions. The NMEP program is vital for the success of our programs and is the basis for providing excellent customer service to our beneficiaries and providers. Additionally, CMS, in coordination with the Administration for Community Living and State Health Insurance Assistance Programs (SHIPS), will work to ensure that NMEP activities continue to provide accurate, comprehensive, understandable information to individuals.

Budget Request: $276.3 Million

The FY 2021 President's Budget request for NMEP is $276.3 million, an increase of $2.6 million above the FY 2020 Enacted level. The additional funding supports CMS' need to maintain a 5 to 7 minute ASA for the 1-800-Medicare call center and operations for the eMedicare initiative. eMedicare is a customer focused initiative with intensive rounds of consumer research and data driven analysis shaping improvements to outreach and customer service. CMS has implemented more robust analytics to ensure that the website features are performing optimally, and meeting user needs (measured by user satisfaction surveys). CMS has also increased our use of email and Short Message Service (SMS) to perform routine digital outreach to Medicare beneficiaries, caregivers, and assisters, actively bringing those users back to the Medicare website on a recurring basis as we launch new features or hit important program milestones such as Medicare Open Enrollment. Details for the FY 2021 eMedicare request are included below.

National Medicare Education Program Budget Summary
(Dollars in Millions)

NMEP Category/Description of Activity in FY 2021	Funding Source	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Beneficiary Materials - National Handbook with comparative information in English and/or Spanish (national & monthly mailing); initial enrollment packages to new beneficiaries; targeted materials only to the extent that funding is available after funding the Handbook.	PM	$29.77	$34.43	$23.38
	Postage	$33.50	$30.00	$30.00
	Total	**$63.27**	**$64.43**	**$53.38**
Beneficiary Contact Center/1-800-MEDICARE - Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives.	PM	$155.13	$149.34	$180.65
	User Fees	$87.77	$84.49	$84.50
	Total	**$242.90**	**$233.83**	**$265.15**
Internet - Maintenance and updates to existing interactive websites to support the CMS initiatives for health and quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov.	PM	$52.01	$46.53	$42.14
	Total	**$52.01**	**$46.53**	**$42.14**
Community-Based Outreach - Collaborative grassroots coalitions; training on Medicare for partner and local community based organizations, providers, and Federal/State/local agencies; and partnership building efforts that provide assistance to Medicare beneficiaries in their communities.	PM	$5.02	$5.39	$5.39
	Total	**$5.02**	**$5.39**	**$5.39**
Program Support Services - A multi-media Medicare education campaign, support services to include Handbook support contracts such as Braille, audio and translation support; minimal level of consumer research and assessment for planning, testing, and evaluating communication efforts to include efforts for targeted populations such as Low Income Subsidy.	PM	$32.68	$38.01	$24.74
	Total	**$32.68**	**$38.01**	**$24.74**
Funding Source Breakout Total	**PM**	**$274.60**	**$273.70**	**$276.29**
	User Fees/1	**$87.77**	**$84.49**	**$84.50**
	Postage	**$33.50**	**$30.00**	**$30.00**
	Total	**$395.87**	**$388.19**	**$390.79**

/1 The User Fees amount reflects total planned obligations in FYs 2020 and 2021.

- *Beneficiary Materials:* The total FY 2021 request is $53.4 million, of which $23.4 million is discretionary budget authority. This estimate is based on historical publication usage data and current market prices for printing and mailing, and a policy in the FY 2021 Budget that gives CMS greater flexibility to distribute the Medicare & You Handbook via electronic means. The Budget assumes an increased number of beneficiaries will opt for electronic receipt of the Medicare & You Handbook in FY 2021. The Medicare & You handbook satisfies numerous statutory requirements including BBA Section 1851 (d) and MMA Section 1860(d) to provide print information to current and newly eligible beneficiaries about Medicare coverage options and available services. The handbook is updated annually and mailed to all current beneficiary households every October. Beneficiaries currently have the option to opt out of receiving a hard copy of the handbook by signing up at Medicare.gov/gopaperless for an electronic copy that gets emailed to them each fall. Updates to rates and plan information occur as needed for monthly mailings to newly-eligible beneficiaries.

  The chart below displays the actual number of Medicare & You handbooks distributed for FY 2018 and the estimated distribution for FY 2019 through FY 2021. The yearly distribution includes the number of handbooks mailed to beneficiary households in October, handbooks pre-ordered for partners and warehouse stock to fulfill incoming requests, and handbooks mailed monthly throughout the year to newly eligible beneficiaries.

The *Medicare & You* Handbook Yearly Distribution
(Handbooks Distributed in Millions)

	FY 2018 Actual	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate
Number of Handbooks Distributed	47.2	47.9	49.5	51.0

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* The total FY 2021 request is $265.2 million, of which $180.7 million is discretionary budget authority. The 1-800-MEDICARE national toll-free line provides beneficiaries with access to Customer Service Representatives (CSRs) who are trained to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week. CSRs respond to inquiries including, but not limited to: authorizations, benefit periods, claims (including denials, filing or status), election periods, deductibles, coverage, eligibility and enrollment, complaints, plan comparisons, prescription drug benefit enrollment and disenrollment, appeal status, etc. Beneficiaries can also use 1-800-MEDICARE to report fraud allegations.

  1-800-MEDICARE CSRs use a variety of call center tools to help beneficiaries, their families, and caregivers make informed health care decisions and to provide both general and personalized customer service in a real-time environment. CMS is continuously exploring new options for streamlining processes and timeframes at 1-800-MEDICARE while seeking to preserve efficiencies and cost-effectiveness, and a high level of beneficiary satisfaction.

The following table displays call volume experienced in FY 2018 and 2019 and the number of calls CMS expects to receive in FY 2020 and FY 2021. All calls are initially answered by the Interactive Voice Response (IVR) system and approximately 30 percent of the calls are handled completely by IVR. At the FY 2021 request level, CMS anticipates an average speed to answer of 5 to 7 minutes.

1-800-MEDICARE/Beneficiary Contact Center Call Volume
(Call Volume in Millions)

	FY 2018 Actual	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate
Number of Calls	23.8	25.4	24.3	24.1

This funding request covers the costs for the operation and management of the BCC including the CSR's activities, print fulfillment, plan dis-enrollment activity, quality assurance, an information warehouse, content development, CSR training, and training development.

- *Internet: $42.1 million.* The Internet budget funds operations and maintenance for three websites. This funding in FY 2021 will provide additional software and hardware upgrades, while providing improvements to the web services offered online and supporting the eMedicare Initiative.

  The http://www.cms.gov website is CMS's public website for communicating with public stakeholders including providers, professionals, researchers, and the press on a daily basis. It supports a variety of critical CMS initiatives, including outreach and education, delivery of materials to stakeholders electronically, and data collection.

  The http://www.medicare.gov website is CMS's public beneficiary-focused website with a variety of real-time, interactive, decision-making tools. These tools enable Medicare beneficiaries and their caregivers to obtain information on their benefits, plans, and medical options. The Medicare Plan Finder, Hospital Compare, Nursing Home Compare, and the Medicare Eligibility tool are included under this activity. The website serves as an effective and efficient communication channel and provides self-service options for U.S. citizens, beneficiaries, and caregivers.

  Beneficiaries also have access to the http://www.mymedicare.gov website to review and update their online account. Beneficiaries can log into mymedicare.gov, a secure website, and check their claims within 24 hours of the processing date. In addition, beneficiaries can use the website to view upcoming available preventive services, a Medicare Summary Notice, or enrollment information, update their email address and add emergency contact information. Beneficiaries can also generate an On-the-Go Report which allows them to download personalized health information and share with their healthcare providers.

  In FY 2021, CMS estimates 460 million page views to http://www.medicare.gov, approximately an eight percent increase in traffic from the page views anticipated in FY 2019. CMS expects page views to grow as the Medicare beneficiary population increases, beneficiaries and their caregivers become more internet savvy, and as CMS

continues to implement more self-service features for beneficiaries to use, in support of a patient-centered approach to these online resources.

www.Medicare.gov **Page Views**
(Page Views in Millions)

	FY 2018 Actual	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate
Number of Page Views for http://www.medicare.gov	413	464	480	510

eMedicare Initiative – CMS' FY 2021 funding needs for eMedicare support ongoing system development activities to modernize and enhance CMS' online customer service tools for Medicare beneficiaries. Specific ongoing development activities that will be underway in FY 2021 include: Medicare.gov integration of personalized capabilities currently on MyMedicare.gov (merging the two websites into one), redesign of the Medicare.gov website, Beneficiary Experience Data & Analytics Platform (BEDAP), Medicare Coverage Tools (MCT), Care Choice Experience (CCXP), Procedure Price Lookup (PPL), enhancements to identify management and account functions (SLS), retirement of legacy tools, and mobile app development. The FY 2021 budget reflects the final major development for the eMedicare new systems, and the beginning of a transition to more operations and maintenance and enhancement work.

Medicare Plan Finder – CMS has launched the updated Medicare Plan Finder as one of many online improvements to enhance the personalized customer experience. The Medicare Plan Finder's new functionalities are intended to supplement and not replace private sector enrollment options where innovation is most likely to occur.

- *Community-Based Outreach: $5.4 million*. CMS relies heavily on community-level organizations, state and federal agencies, providers, and other partners to serve as trusted sources of CMS administered program information for consumers, particularly for hard-to-reach populations, and must provide these partners with accurate and up-to-date information and tools that equip them to effectively counsel and assist their constituencies.

  FY 2021 funding is requested for continued support and maintenance of the new Learning Management System and all related tasks. This funding will also provide the resources needed to support face-to-face sessions, web-based training, and regularly scheduled live- and pre-recorded webinars required to educate stakeholders to ensure eligible individuals enroll in CMS programs and make optimum use of their benefits. The request also supports the full availability of the Beneficiary Experience Data Analytics Platform (BEDAP) system which includes segmented outreach to Medicare beneficiaries, caregivers, and coming-of-agers- with a wider array of personalized use cases and higher levels of testing and analysis.

- *Program Support Services: $24.7 million.* This activity provides funding for accessible materials for low vision/blind and disabled beneficiaries (audio, Braille and large print and e-reader designs), electronic and composition support for the Medicare & You Handbook, mail file creation for the statutory October mailing of the Medicare & You Handbook, NMEP consumer research and assessment (including consumer testing of

the Medicare & You handbook), a publication ordering web site for partners that support the Medicare education program, support for the Advisory Panel on Outreach and Education, and the creation/dissemination of mobile applications for accessing NMEP products and information. This funding also supports the multi-media education program.

The Multi-Media Medicare Education Campaign raises beneficiary awareness about the coverage options, benefits, and services available through Medicare. It is designed to help people with Medicare and those who help them (caregivers including family and friends, information intermediaries, and others) maximize the use of their Medicare benefits to maintain their health, resulting in healthier beneficiaries and lower costs for Medicare. The campaign also promotes Medicare's official information sources including 1-800-MEDICARE, medicare.gov, mymedicare.gov, Medicare & You Handbook, and other localized partners and resource.

In addition to the Program Management budget authority request, the NMEP budget request assumes $84.5 million in user fees and $30.0 million is postage funding bringing the total FY 2021 budget request for NMEP to $390.8 million, an increase of $2.6 million above the total FY 2020 Enacted level.

Consumer Outreach

CMS supports outreach to all eligible persons who can obtain health insurance through the private market, as it relates to CMS programs. The activities included in this section reflect programs that CMS has implemented either based on statutory requirement or good government to inform consumers on health coverage across Medicaid, Medicare, CHIP, and the private insurance market. CMS' outreach activities for consumers are based on proven strategies utilized by the NMEP program to support CMS' Medicare and Medicaid beneficiaries.

Each year CMS incorporates best practices from last open enrollment (OE) to make CMS media more efficient and effective. Previous OEs have taught CMS lessons about effective messages and tactics to reach the uninsured Americans who need information and assistance the most. This request provides support to maintain and update general consumer information for private insurance on www.Healthcare.gov and allows CMS to tailor outreach programs to the disenfranchised and minority groups. Ongoing funding will make outreach more effective, helping more people get coverage, stay healthy, and ensure that consumers are receiving up-to-date information regarding their healthcare coverage.

Budget Request: $4.5 Million

The FY 2021 President's Budget request for Consumer Information and Outreach is $4.5 million, a decrease of $4.2 million below the FY 2020 Enacted level.

- *General Consumer Outreach*: $4.5 million. Federal delivery of health services and funding of programs to maintain and improve the health of American Indian and Alaska Natives (AI/AN) are consistent with and required by the federal government's historical and unique legal relationship with Indian Tribes. The goal of the Indian Health Care activity is to expand the reach of CMS programs for AI/AN's. Ongoing AI/AN outreach contracts will support the continued implementation of a well-developed, flexible and successful quality outreach strategy that provides critically needed and culturally

appropriate resource materials to increase the enrollment of AI/AN beneficiaries in CMS programs including private insurance, Medicaid, Medicare, and an increased focus on dually eligible populations.

CMS also plans to fund the Coverage to Care (C2C) initiative, a health literacy initiative designed to assist consumers with any type of insurance (Medicare, Medicaid, Exchanges, private insurance) to understand their health insurance and how to use it for primary care and preventive services. C2C depends on collaboration with community groups, consumers, and providers to focus on prevention, regular primary care, and proper utilization of emergency care to encourage reduced costs and better health outcomes. C2C empowers stakeholders by providing digital and print resources and messages to enable a patient-centered approach for accessibility and affordability.

CMS plans to fund outreach and education activities focused on supporting minority health and reducing health disparities. This effort will consist of increasing engagement of patients, doctors, states and stakeholders. It also includes website content development, media outreach, branding, messaging, stakeholder engagement, and development and printing of toolkits and materials for partners, beneficiaries, and the public.

VII. INFORMATION TECHNOLOGY

Program Description and Accomplishments

Systems and Support

Information Technology Systems and Support activities provide infrastructure and support for applications and operations that are used across the agency. These activities provide CMS the capability to quickly expand to address future system needs, adopt new and more efficient technologies, and support new programs. CMS must continue to invest in expansions of software, licensing and processing capacity to manage system growth, and consolidation and replacement of end of life and/or less efficient equipment in its efforts to modernize its information technology. IT systems and support activities also include security and governance within CMS, which provide the standards and guidelines for compliance and response capabilities. CMS protects our networks and information systems against the continual attacks of malicious cyber actions through a comprehensive 24/7 cyber threat monitoring program.

In FY 2021, CMS will continue to invest in the transition to the Virtual Data Center, which supports Medicare Part C and D operations and enterprise shared services. CMS also continues to fund infrastructure for the Health Plan Management System (HPMS), which ensures that nearly 800 MA organizations and Part D plans are fulfilling the various statutory, regulatory, and administrative requirements of those programs.

Budget Request: $450.0 Million

The FY 2021 request for Information Technology Systems and Support activities is $450.0 million, a decrease of $137.6 million below the FY 2020 Enacted level. The decrease in funding is attributed to CMS's upfront investment in FY 2020 toward enhancing the CMS cybersecurity program and the additional funding in FY 2020 dedicated to the development

of a disaster recovery environment that enables CMS to optimize and then migrate systems to the cloud. The request for FY 2021 is necessary to continue ongoing IT operations, including making necessary investments in existing systems that support improvements in the effectiveness and efficiency of CMS operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies. The majority of funding within in this category supports the Baltimore Data Center, Enterprise Licensing, and the Integrated Data Repository.

The following are highlighted priorities within the system and support category:

IT Security: $86.5 million. CMS faces a growing cybersecurity threat every day due to the outdated security infrastructure maintained within the agency. CMS has successfully implemented Continuous Diagnostics and Mitigation (CDM) at the core data center and initiated progress beyond the Baltimore Data Centers, targeting Data Centers containing high value assets and large numbers of FISMA systems. It will take multiple years and additional resources in order to comply with OMB's mandate to fully implement CDM across the entire landscape, establish and maintain ongoing authorization, automate Indicators of Compromise (IOCs) sharing with data centers and, increase the viability of cloud security and the Development Security Operations programs. OMB and HHS have accelerated the timeline for all CDM phases, which means CMS will need to plan and execute multiple CDM phases simultaneously. The FY 2021 request includes funding to continue and expand CDM work at the new accelerated pace. Protecting beneficiary data continues to be a top priority at CMS.

Medicare Payment Systems Modernization (MPSM): $15.9 million. The Medicare FFS Claims processing systems, otherwise known as the FFS shared systems, were developed on the mainframe over 40 years ago and CMS continues to add on to those systems to meet critical Medicare business needs. These claims processing systems were written in legacy COBOL and Assembler programming languages and have not been modernized since their inception. As the Medicare program continues to evolve, CMS is concerned that these systems will not be able to keep up with the changing needs of the program and regulations. A fundamental technological system change is necessary to support both existing payment models with the influx of covered beneficiaries, and to provide flexibility for various value-based payment models as they are conceived and implemented.

CMS had engaged its Medicare Contractor software developers, the United States Digital Services, and procured new vendors through a Blanket Purchase Agreement whose expertise includes cloud development, agile development and delivery, and a modern holistic focus on human-centered design. We have developed new Application Programming Interfaces (APIs) that facilitate more efficient use of data by our current claims processors with the potential to serve other systems and users in the future. We've programmed key pieces of CMS pricing software in Java and deployed that on the Cloud. This has improved our ability to react to problems quickly and efficiently, with a case example yielding a 50% reduction in time-to-fix. Lastly, we have laid an operational foundation to support current and future work, introduced automated monitoring tools for both cloud and mainframe activity, and are continually exploring technical innovations and tools to support the overall modernization effort. This funding will be used to continue these efforts, expanding APIs and offering more pricing as a Service in the Cloud, Prototyping additional services and technology, and for additional modernization of pieces of payment system functionality that will be determined through current research and design.

Continuity of Operations Disaster Recovery (COOP DR): $16.0 million. CMS is undergoing a revitalization of the agency-wide COOP program to improve CMS' recovery posture and operational capability. Recent audit findings have determined the programs and systems that support CMS Mission Essential Functions (MEFs) require increased capabilities to meet federal requirements. This funding will address gaps identified in the CMS COOP program and allow systems supporting CMS MEFs improved disaster recovery (DR) capability. This funding will allow CMS to migrate to the cloud environment to enhance our COOP DR capacity, modernize old code, and promote efficiencies in processing. Funding will also be used to enhance the testing, training, and exercising element of the COOP DR program to further validate appropriate recovery strategies.

VIII. OTHER INITIATIVES

Program Description and Accomplishments

These activities reflect Departmental wide concerns, nationwide health issues (i.e. the opioid epidemic), and vulnerabilities in CMS' operations. These activities are mostly new to CMS Program Management and, pending policy decisions and successful outcomes, may become part of CMS' ongoing operations.

Opioids

Budget Request: $13.0 Million

The FY 2021 President's Budget request for Opioid Initiatives is $13.0 million, a decrease of $1.5 million below the FY 2020 Enacted level. CMS requests funding to implement unfunded SUPPORT act provisions in addition to supporting outreach and education for patients, providers, prescribers, and other organizations to emphasize awareness of best practices recommended by SUPPORT Act provisions. CMS will also work with its contractors and other agencies to implement outreach efforts. The request will be used for data and information technology needs, provider monitoring and auditing, performance measurement, and claims analysis.

Medicare Quality Improvement – Value-Based Transformation

Budget Request: $144.4 Million

The FY 2021 President's Budget Program Operations request for Medicare Quality Improvement and Value-Based Transformation is $144.4 million. This request targets Medicare quality improvement and will support increasing patient safety, making communities healthier, better coordinating post-hospital care, and improving clinical quality. These activities support the Administration's priorities to enhance quality transparency and foster value-based healthcare transformation.

Quality Payment Program

Budget Request: $40.0 Million

The FY 2021 President's Budget request for the Quality Payment Program (QPP) is $40.0 million, a decrease of $2.3 million below the FY 2020 Enacted level. CMS anticipates the MACRA Section 101 mandatory funding, which provided for initial implementation of the QPP, will sunset in FY 2020. Therefore, this request will enable the work to continue in FY 2021 through Program Operations funding.

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Federal Administration

(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
BA	$732,533	$732,533	$772,533	$40,000
Indirect Costs	$145,366	$147,595	$141,269	($6,326)
Program Level	$877,899	$880,128	$913,802	$33,674
FTE 1/	4,360	4,222	4,286	64

1/ Excludes staffing funded from directly appropriated funding sources and reimbursables.

Authorizing Legislation – Reorganization Act of 1953
Authorization Status – Permanent
FY 2020 Authorization – One Year
Allocation Method – Direct, Contracts, Other

Program Description and Accomplishments

Federal Administration funds the majority of routine operating expenses in support of agency activities for a variety of health care financing programs. Funding covers employee compensation, rent, utilities, information technology, contracts, supplies, equipment, training, and travel. Many of these costs are impacted, on an annual basis, by escalation factors akin to inflation, such as increased costs for benefits paid on behalf of the employee and annual cost of living adjustments.

CMS has always been deployed throughout the country; however, to focus on facilitating greater cohesion and integration within our ranks, CMS is now organized to provide a singular customer experience, a singular CMS, One CMS. This integration will enable CMS to better serve our stakeholders and improve the development and execution of our policies. Also, our staff nationwide will work closely together to ensure the consistency of our operations. These employees accomplish the CMS mission by writing health care policies and regulations; setting payment rates; developing national health care operating systems; contractor monitoring; developing and implementing customer service improvements; providing education and outreach to beneficiaries, consumers, employers, and providers; implementing guidelines to fight fraud, waste, and abuse; and assisting law enforcement agencies in the prosecution of fraudulent activities. CMS employees also accompany State surveyors to health care facilities to ensure compliance with CMS health and safety standards; and assist States with Medicaid, Children's Health Insurance Program (CHIP), and other health care programs. CMS also has staff in the fraud "hot spot" offices in areas known to have high incidences of fraud and abuse. They can quickly detect and respond to emerging schemes to defraud the Medicare program. Through CMS' nationwide footprint, we are positioned where our beneficiaries need us allowing us to accomplish our mission as One CMS.

The Homeland Security Presidential Directive 12 (HSPD-12) calls for all federal employees and contractors to use a standard smart credential to access federal buildings and information systems. Federal Administration is one of the funding sources that supports this activity, and in FY 2020, CMS projects to credential up to 4,104, through this effort.

CMS is making strides to safeguard the data of the population we serve.

In FY 2021, CMS will conduct approximately 5,000 background investigations by the end of the fiscal year. Historically, funding has enabled CMS to maintain the lifecycle maintenance program ensuring timely replacement of critical equipment required for the credentialing process and preventing system outages due to hardware malfunction. Additionally, CMS has purchased the supplies required to support the HSPD-12 program including the purchase of PIV card stock, lanyards, and credential holders.

This request includes $1.6 million in FTE costs associated with CMS's value-based healthcare transformation activities. In addition, $3.0 million is included to support United States Digital Service (USDS) administrative staffing costs at CMS.

Personnel and associated costs for programs and activities, where specific funding sources are available, are not included in the Federal Administration request. In order to ensure indirect costs are appropriately applied to these funding sources, CMS utilizes a cost allocation methodology to offset some costs that would otherwise be funded out of the Federal Administration account. In FY 2021, CMS estimates that $141.3 million will be available from indirect cost allocations, which is above the discretionary funding request.

Funding History

Fiscal Year	Budget Authority
FY 2017	$732,533,000
FY 2018	$732,533,000
FY 2019	$732,533,000
FY 2020 Enacted	$732,533,000
FY 2021 President's Budget	$772,533,000

Budget Request: $772.5 million

The FY 2021 President's Budget request for Federal Administration is $772.5 million. In addition, CMS projects $141.3 million would be available from indirect cost allocations; bringing the total program level to $913.8 million.

Federal Administration
Program Level Summary Table
(Dollars in Thousands)

Objects of Expense	**FY 2019 Final**	**FY 2020 Enacted**	**FY 2021 President's Budget**	**FY 2021 +/- FY 2020**
Personnel Compensation and Benefits	$678,850	$684,625	$710,967	$26,342
Travel	$5,464	$5,389	$5,464	$75
Rent, Communications and Utilities	$35,630	$35,630	$36,650	$1,020
Printing	$2,453	$2,456	$2,453	($3)
Contractual Services	$151,087	$147,835	$153,853	$6,018
Service and Supply Fund (non-add)	*$44,753*	*$46,901*	*$46,901*	*$0*
Administrative Services (non-add)	*$7,705*	*$7,866*	*$7,332*	*($534)*
Administrative IT (non-add)	*$40,366*	*$41,027*	*$44,392*	*$3,365*
Inter-Agency Agreements (non-add)	*$2,778*	*$2,778*	*$2,883*	*$105*
Administrative Contracts and Intra-Agency Agreements (non-add)	*$55,485*	*$49,263*	*$52,345*	*$3,082*
Supplies	$969	$969	$969	$0
Training	$3,446	$3,224	$3,446	$222
Total, Federal Administration	**$877,899**	**$880,128**	**$913,802**	**$33,674**

/1This table and below narrative reflect Program Level funding, which include appropriated resources in addition to funds from CMS indirect cost allocations.

- *Personnel Compensation and Benefits:* $711.0 million. The FY 2021 request includes $711.0 million in discretionary funding, an increase of $26.3 million above the FY 2020 Enacted Level. The requested funding supports 4,286 direct Full-Time Equivalents (FTEs), an increase of 64 FTEs as compared to the FY 2020 Enacted Level.

  This category covers the full range of civilian and Commissioned Corps employees pay, within grade increases, awards and overtime, as well as fringe benefits. Commissioned Corps are entitled to additional benefits including housing and other allowances. The FY 2021 FTE estimate includes a 1.0 percent pay inflation assumption for civilian employees, a 2.6 percent pay inflation is included for Commissioned Corps staff, and a 1.0 percent inflation estimate to cover the increase in benefits costs. CMS' staffing levels, tied with related compensation and benefits expenses, are largely workload-driven. Staffing levels funded from the Federal Administration line will enable CMS to execute Secretarial priorities, such as expanding value-based healthcare, lowering the price of prescription drugs, pursuing health insurance reform, and addressing the opioids crisis while maintaining and improving the performance of our traditional programs, including Medicare, Medicaid, CHIP, and other federal health programs, to ensure they are successfully delivered with the highest quality. Additional CMS staffing costs are funded through other directly appropriated accounts.

- *Travel:* $5.5 million. The FY 2021 request includes $5.5 million in program level funding, an increase of $0.07 million above the FY 2020 Enacted Level. CMS' travel is dictated by our mission, comprising of on-site visits to contractors, states,

healthcare facilities, and other providers. Since CMS administers its programs primarily through contractors or third parties, site visits are critical to managing and evaluating these programs and to ensuring compliance with the terms and conditions of contracts and cooperative agreements. Site visits also allow CMS to ensure our beneficiaries and consumers are receiving quality care and providers are not engaged in fraudulent practices.

- *Rent, Communications, & Utilities*: $36.7 million. The FY 2021 request includes $36.7 million in program level funding, an increase of $1.0 million above the FY 2020 Enacted Level. This category provides funding for CMS' offices, including rent and operational costs, which are calculated by the General Services Administration on behalf of CMS. Other items in this category include contract labor costs, such as grounds maintenance, cleaning, and trash and snow removal.

- *Printing:* $2.5 million. The FY 2021 request includes $2.5 million in program level funding, a slight decrease below the FY 2020 Enacted Level. The largest expense in this category is for printing notices in the Federal Register and Congressional Record. CMS is required to publish regulations that adhere to notice and comment rulemaking procedures. Historically, one major piece of new authorizing legislation involving CMS' programs is enacted annually. Each piece of legislation requires CMS to publish regulations that implement the numerous provisions in these bills.

- *Contractual Services:* $153.9 million. The FY 2021 request includes $153.9 million in program level funding, an increase of $6.0 million above the FY 2020 Enacted Level. Contractual Services include our daily operations via contracts and interagency agreements (IAAs). Funding supports critical information technology infrastructure and services which provide CMS employees with a secure and technologically-efficient workplace. CMS has also made a concerted effort to promote a more user-friendly IT environment for employees with integrated data, voice, and video services that provide seamless connections between meeting rooms, work stations, and remote locations. Essential IAAs such as legal services with the HHS's Office of General Counsel and security services with the Department of Homeland Security are also included within this category and are crucial in supporting CMS operations. In addition, the CMS share of the Department of Health and Human Services Program Support Center and other shared expenses including payroll, financial management, and e-mail systems are funded within this section. The HSPD-12 initiative is partially funded within this category and provides support for continuous credentialing of employees and to obtain essential resources critical for operations to meet the requirements of Federal policies. The majority of the requested increase will support annual inflationary cost adjustments within the contracts.

- *Supplies:* $1.0 million. The FY 2021 request includes $1.0 million in program level funding, the same as the FY 2020 Enacted Level. This category funds general everyday office supplies and materials for CMS employees, including new and replacement furniture, office equipment, paper, and small desktop-related IT supplies.

- *Training:* $3.4 million. The FY 2021 request includes $3.4 million in program level funding, an increase of $0.2 million above the FY 2020 Enacted Level. This category supports continuous learning of technical, professional, and general business skills with special emphasis on leadership and management development, which includes certifications for staff, such as actuaries, contract specialists, financial managers, nurses, and other health professional specialists. Funding also supports mandatory agency wide trainings such as Reasonable Accommodation, Alternative Dispute Resolution, and Ethics.

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Medicare and Medicaid Survey and Certification
(Dollars in Thousands)

	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Program Management				
Discretionary Appropriation	$397,344	$397,334	$442,192	$44,858
(non-add) Quality Improvement – Value Based Transition	$0	TBD	$9,000	--
Offsetting Collections				
Clinical Laboratory Fees	$63,600	$64,936	$66,429	$1,493
Mandatory Appropriation				
IMPACT P.L. 113-185. Hospice Surveys[/1]	$5,276	$5,293	$5,625	$332
Grants to States for Medicaid (S&C)	$308,315	$286,750	$296,000	$9,250
Quality Improvement Organization	$7,000	$0	$0	$0
Grand Total (Comparable Adjustment)	**$781,535**	**$754,313**	**$810,246**	**$55,933**

1/ Funding provided through IMPACT P.L. 113-185 Section 3 for hospice surveys in FY 2019 and FY 2020 is subject to 6.2 and 5.9 percent sequester respectively – sequester reductions are not displayed above.

Authorizing Legislation - Social Security Act Title XVIII, Sections 1151-61, 1862(g), 1864; SSA Title XIX Section 1901; and Public Health Service Act Title XIII, Section 353.

FY 2020 Authorization - Public Law 116-94

Allocation Method – Contract and Grants

Program Description and Accomplishments

Survey and Certification (S&C) is a CMS administered program that ensures healthcare providers across the Nation meet applicable quality standards through onsite, objective, and outcome-based verification activities carried out by knowledgeable and trained individuals. CMS' S&C program serves residents and clients receiving care from approximately 340,000 Medicare and Medicaid-certified institutional providers, suppliers, and laboratories. CMS takes action when quality standards are not met by utilizing appropriate remedies, which can include imposition of civil monetary penalties (CMPs) or the termination of participation in the Medicare, Medicaid, and the Clinical Laboratory Improvement Amendments (CLIA) program.

CMS accomplishes its quality assurance functions through a collaboration with States and their respective State Survey Agencies (SAs), private accrediting organizations (AOs), and private sector survey organizations to conduct specialized surveys and investigations. When significant problems are identified, either through onsite observation during periodic comprehensive surveys or from complaint investigations, CMS is authorized to impose remedies on providers, suppliers, or Clinical Laboratories. Failure of the provider to implement suitable remedial action for serious deficiencies can result in termination from the Medicare and/or Medicaid programs. Thus, CMS' S&C program fulfills a key gate-keeper role in the well-being and safety of Medicare beneficiaries and Medicaid recipients.

In the case of clinical laboratories, failure to implement corrective actions may also result in sanctions, including revocation of CLIA certificates. Once revoked, a laboratory can no longer perform any human specimen testing including, waived, provider performed microscopy, and moderate or high complexity testing, used for healthcare purposes as delineated in the Clinical Laboratory Improvement Amendments of 1988.

The S&C program is funded by multiple sources. Medicare S&C activities are funded via the Program Management annual discretionary appropriation and a small portion of mandatory funds which are limited to hospice surveys. Clinical lab work is funded via user fees and thus is self-financed. Lastly, S&C activity for the Medicaid program is funded from the Grants to States for Medicaid account; these costs are shared with States.

CMS prioritizes the S&C program funding required by law and evidenced based policies to ensure the quality and safety of patients seeking care in facilities certified by CMS. Accordingly, CMS requires State Survey Agencies and survey contractors to prioritize:

1. Investigation of reported complaints;
2. Survey and recertification of statutory facilities such as nursing homes, home health agencies (HHAs), and hospice as required by current law;
3. Survey and recertification of non-statutory facilities as required by CMS policy

CMS exercises oversight of SAs via contracts with national surveyors. These contractors perform mandatory comparative surveys of SAs to ensure States are effectively investigating and enforcing compliance with the Medicare health and safety standards. CMS also contracts for other programmatic activities, such as surveyor training, AO oversight, improving key processes such as the survey process for nursing homes, and identifying new methods for collecting and reporting data used to evaluate survey variation and state performance.

To improve CMS' existing data systems, funding is also used to support a broad array of information technology efforts which make program information, such as deficiency and survey reports, publicly available in an understandable and more accessible format. An example of such efforts includes CMS' Five-Star Quality Rating System on the Nursing Home Compare website.

Recent S&C program accomplishments include the implementation of two initiatives, *Improve Care in Long-Term Care Facilities* and *Improve Oversight of Accrediting Organizations*, which are highlighted below. These two initiatives seek to ensure continued quality and safety for the Nation's health care services.

Initiative 1: Improve Care in Long-Term Care Facilities

In FY 2021, CMS projects that Long-Term Care (LTC) facilities will account for 33.2 percent of all Medicare and Medicaid participating facilities, the largest single facility type. Given the number of LTC facilities and the overall level of risk to beneficiary health and welfare, CMS fittingly places high programmatic priority on maintaining and improving the quality of care and transparency in these facilities. The goal of the LTC initiative is to protect resident health and safety by improving the identification of noncompliance and remediation. This effort directly addresses key questions including: How will the quality of life and care improve for nursing home residents? How will survey effectiveness and efficiency improve?

CMS has already achieved a number of key milestones related to this initiative in recent years, including:

- Implementation of a revised survey process and training that accompanied the first revisions to the LTC regulations in 25 years;
- Implementation of a revised Federal Monitoring Survey process;
- Improved oversight of abuse and neglect through reporting criteria for facility-reported incidents, and making referrals to law enforcement;
- Improved consistency of CMS' enforcement actions;
- Targeted after-hours and weekend surveys for LTC facilities that fail to meet RN staffing levels;
- Revision of State Performance Standards System measurement and improved monitoring of health, safety and emergency preparedness compliance;
- Improved transparency and the use of publicly-reported information on Nursing Home Compare and the Five-Star Quality Rating System to monitor trends and to drive quality improvement; and,
- Reinvestment of CMP funds to support activities to further improve resident health and safety, including support for residents in the event of facility closure, joint training of facility staff and surveyors, technical assistance, and the appointment of temporary management.

Initiative 2: Improve Oversight of Accrediting Organizations

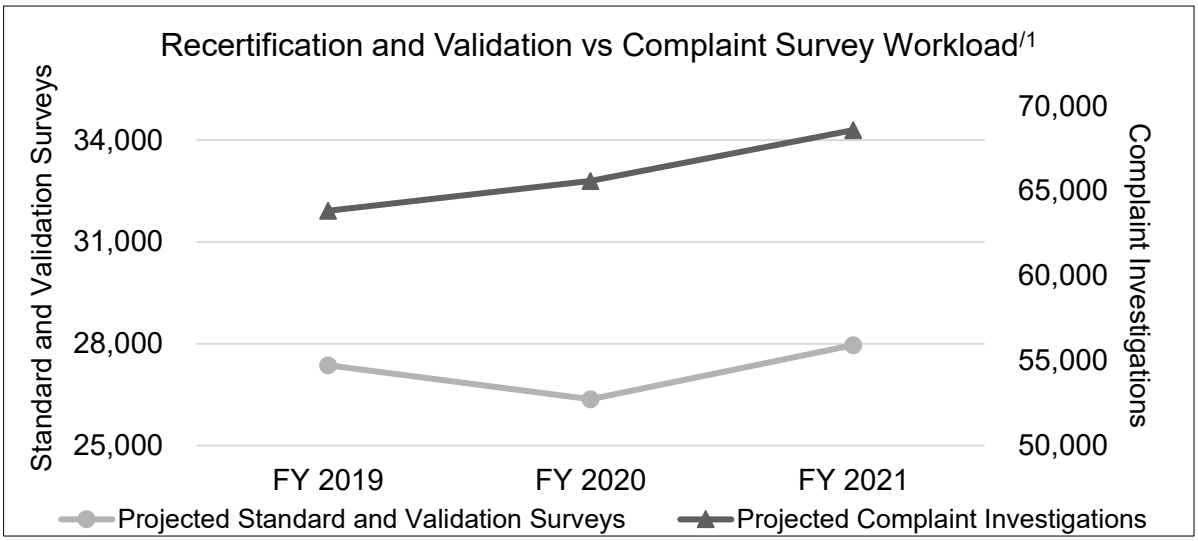
AOs receive deeming authority from CMS to affirm that AOs' health and safety standards meet or exceed those of Medicare. There are currently 11 CMS-approved AOs, each of which surveys one or more different types of facilities including hospitals, HHAs, hospices, ambulatory surgical centers, and ESRD facilities. Facilities surveyed and certified through AOs are considered "Deemed" to match CMS' Conditions of Participations (COPs).

In response to ongoing concerns, such as CMS noticing a growth in survey disparity rates between non-deemed and deemed facilities, CMS has developed this strategic initiative to improve its oversight of AOs. CMS aims to improve the transparency and effectiveness of the AO program, thus strengthening our commitment to quality and patient safety. This initiative is designed to answer questions surrounding: How has compliance with Medicare quality and safety standards improved care in acute care settings? Has increased oversight improved disparity findings? And, how has CMS improved partnerships and communications with AOs? CMS has proposed crucial milestones to implement this initiative:

- Public posting of information about AO performance and ownership;
- Improved guidance pertaining to AO conflict of interest;
- Establishment of an AO Liaison Program; and,
- AO validation survey redesign

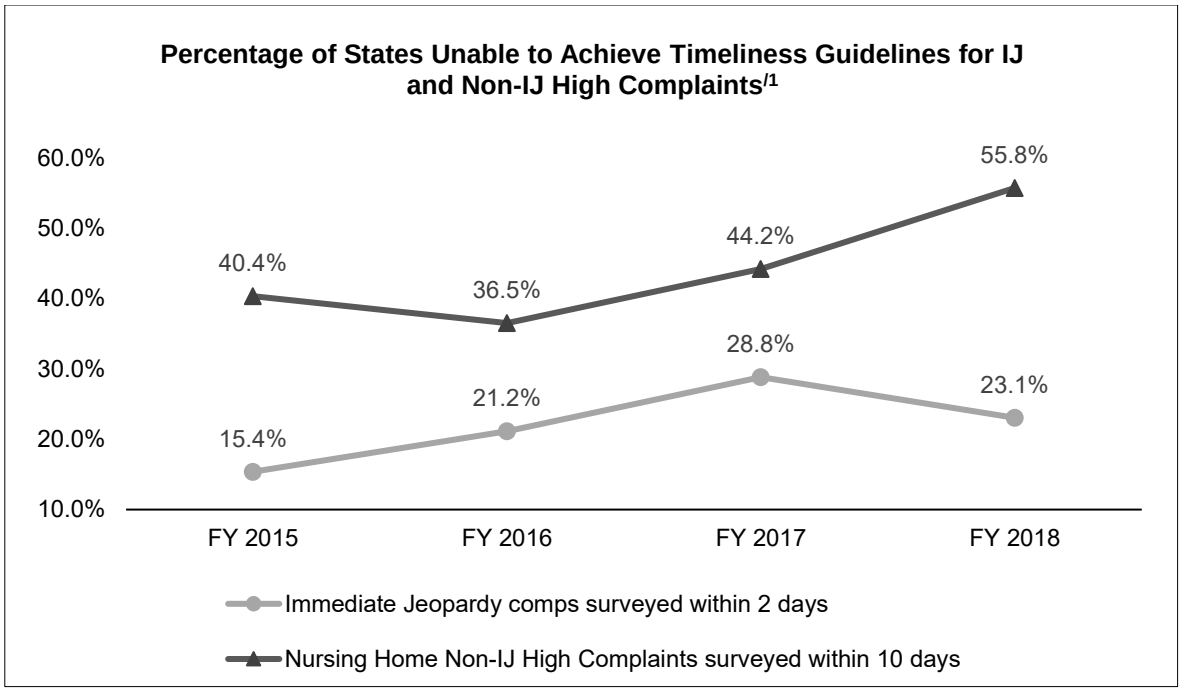
While there are a number of factors that determine the overall quality of care in a hospital setting, CMS is committed to significantly reducing the number of serious health and safety violations in accredited hospitals each year. A number of important steps have been taken to improve the survey processes and oversight responsibilities to continually improve CMS-identified major risk areas, which could jeopardize the ongoing effectiveness of the S&C program.

The S&C program has not realized an increase in its annual discretionary appropriation since FY 2014, which limits the program's capacity to perform routine recertification and validation surveys. As a result, the SAs' ability to address issues proactively through standard surveys is limited, making complaint surveys the primary oversight mechanism for many provider types. In some cases, issues that could be easily identified during standard health surveys go unaddressed becoming more difficult and expensive to correct. At times, these issues escalate to possibly life threating circumstances, as substantiated through reported complaints. With the additional funding in this request, CMS will continue to address complaints but also will increase the SAs ability to complete standard surveys, recertification, and validations.



1/ Includes both Medicare and Medicaid facilities.
2/ FY 2019 to FY 2021 are projections.

Complaints categorized as Immediate Jeopardy (IJ) and Non-IJ High, are considered top priority to ensure the safety and well-being of the beneficiary community. CMS provides performance standards to SAs, detailing acceptable timelines to address varying levels of complaints. The standard timeline for IJ complaints requires SAs to complete an onsite assessment within 2 days of such a complaint. The next level of complaint, Non-IJ High, although not as severe, requires the SAs to complete an assessment within 10 days of the complaint. As indicated in the table below, the number of states unable to maintain performance standards for both IJ and Non-IJ High complaints (95 percent compliance rate is considered passing) were both above 20 percent in FY 2018. In FY 2018, states' inabilities to assess non-IJ complaints significantly increased with over half of the SAs (55.8 percent) unable to meet the 10-day timeline.



/1 Includes both Medicare and Medicaid facilities.

Funding History

Fiscal Year	Discretionary Appropriation
FY 2017	$397,334,000
FY 2018	$397,334,000
FY 2019	$397,334,000
FY 2020 Enacted	$397,334,000
FY 2021 President's Budget	$442,192,000

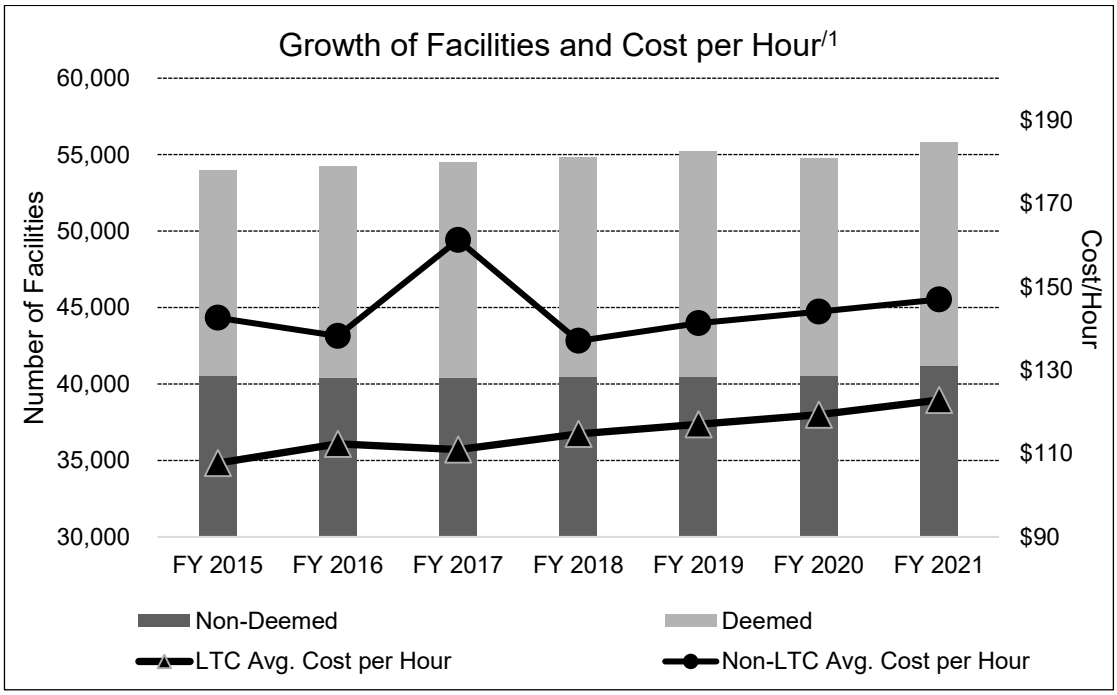
Budget Request Discretionary Appropriation: $442.2 million

The Program Management discretionary FY 2021 President's Budget request is $442.2 million in two-year funds, $44.9 million above the FY 2020 Enacted level. This request supports survey intervals closer to CMS policy levels and provides better opportunities to assess and correct quality issues before they manifest as substantiated complaints. At this funding level, CMS will be in better position to achieve the Strategic Initiative to ensure safety and quality by reducing the number and severity of substantiated complaints. As in past years, CMS will prioritize funding to meet the statutory requirements of the S&C program. Overall, this request includes funding for SAs surveys, along with ongoing contract support to strengthen quality improvement efforts, improve national survey consistency, improve AO oversight, and implement GAO and OIG recommendations to promote gains in efficiency and effectiveness. Above all, at this funding level, CMS' ability to reach patients before the need for a complaint (either IJ or Non-IJ High) increases.

As indicated in the table below, the S&C program has faced increased costs due, in part, from growth in the number of beneficiaries (which has created a demand for more facilities), surveyor wage growth, and improvements in quality standards. From FY 2015 to FY 2019, participating facilities grew by nearly 1 percent, or 586 facilities. During this time

period, deemed facilities made up the majority of this growth, with an increase of nearly 10 percent, whereas the total number of non-deemed facilities decreased by 1.5 percent. This growth in the number of deemed facilities reinforces the significance of the aforementioned Initiative, *Improve Oversight of Accrediting Organizations*.

The overall average cost per hour to conduct Survey and Certification workload has increased by 3.8 percent between the end of 2015 and end of 2019. This is due in part to cost growth at the state level, as states have increased wages to attract and retain surveyors, who are medical professionals in high demand. On average, the LTC cost per hour increased by nearly 10 percent, while non-LTC cost per hour was almost flat. Finally, between FY 2015 and FY 2019, the implementation of revised COPs has resulted in average survey length increases by 6 percent, adding to the growth in costs to conduct surveys, certifications, and investigations. The graph below demonstrates the overall growth in number of facilities, the incremental increase of more facilities entering the Medicare and Medicaid programs through accreditation (i.e. the "deeming" process), and the increase in costs to conduct surveys for LTC and non-LTC facilities.



1/ Includes both Medicare and Medicaid facilities.

CMS' S&C program will also receive $5.6 million from the Improving Medicare Post-Acute Care Transformation (IMPACT) Act to help keep hospice survey frequencies at a 3-year rate. The total, FY 2021, S&C Medicare program level funding is $447.8 million, which will be distributed to states to conduct surveys and investigations. This level also includes funding for the S&C program's technical infrastructure enhancement and maintenance activities.

- *Total State Direct Survey Budget request* is about $393.0 million for states to conduct surveys and about $10.0 million to pay for administrative cost. This is an increase of about $40.0 million above FY 2020 Enacted. In addition, CMS plans to shift the responsibility for psychiatric hospital survey and certification to SAs, an effort historically conducted by federal contractors, as the SAs have developed the skillset required to take on this type of facility which will provide a more complete view of the facility's overall condition.

The following table provides the projected survey completion rates from FY 2019 to FY 2021 for Medicare and Medicaid facilities. The survey rates include initial surveys, recertification, and validations. The table also provides statutory facilities' survey frequency interval standards that are set in statute; and the non-statutorily mandated facilities' survey frequencies are based on CMS' administrative policy. The percentages indicate the completion rate of the facility for a given year in relation to the survey interval. For example, ESRD facilities have a three-year survey frequency interval. Therefore, 33 percent, or one-third of the ESRD facilities should be surveyed each year. The percentages are the completion rates of the 33 percent of ESRD facility surveys. Following this methodology, the table shows that in FY 2019, CMS projects that 23.1 percent of one-third of all ESRD facilities were surveyed.

FY 2019 to FY 2021 Projected Survey Frequency Rates

Provider Type /1	Survey Frequency Intervals	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Skilled Nursing Facility	Max 15.9 months; Min 12.9 months	100.0%	100.0%	100.0%
		$14.420	$16.105	$17.753
Skilled Nursing Facility/Nursing Facility	Max 15.9 months; Min 12.9 months	100.0%	100.0%	100.0%
	Medicare	$263.238	$279.893	$299.779
	Medicaid	$216.886	$224.119	$240.285
Nursing Facility (Medicaid)	Max 15.9 months; Min 12.9 months	100.0%	100.0%	100.0%
		$8.082	$8.935	$8.658
ICF/IID (Medicaid)	Max 15.9 months; Min 12.9 months.	100.0%	100.0%	100.0%
		$44.720	$39.926	$47.888
HHAs	Max 36.9 months	100.0%	100.0%	100.0%
	Medicare	$14.165	$14.875	$17.380
	Medicaid	$12.629	$13.478	$12.821
Hospices /2	Max 36.9 months	100.0%	100.0%	100.0%
		$10.434	$9.062	$12.533
Hospitals	3 Years CMS Admin Policy	/4	/4	/4
		$2.545	$2.379	$1.824
Psych Hospital/3	6 Years CMS Admin Policy	N/A	N/A	/4
		N/A	N/A	/5
Transplant Hospitals	5 Years CMS Admin Policy	/4	/4	/4
		$.004	/5	$.008
ESRDs	3 Years CMS Admin Policy	55.1%	23.1%	48%
		$16.739	$8.436	$14.119
OPTs	6 Years CMS Admin Policy	55.2%	23.2%	58.6%
		$.677	$.311	$.749
CORFs	6 Years CMS Admin Policy	/4	/4	/4
		$.001	$.001	/5

Provider Type /1	Survey Frequency Intervals	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Portable X-Rays	6 Years CMS Admin Policy	/4	/4	/4
		$.009	$.003	$.003
RHCs	6 Years CMS Admin Policy	/4	/4	/4
		$.072	$.076	$.087
ASC	3 Years CMS Admin Policy	55.1%	23.1%	50%
		$7.607	$3.678	$6.497
CMHCs	6 Years CMS Admin Policy	/4	/4	/4
		$.008	$.025	/5
Deemed Facilities				
HHAs	5% Year Sample	77.4%	61.4%	79.4%
	Medicare	$.921	$.436	$.983
	Medicaid	$1.490	$1.680	$1.500
Hospitals	5% Year Sample	55.2%	23.1%	58.3%
		$27.735	$27.152	$28.326
Hospices	5% Year Sample	54.8%	22.6%	58.3%
		$1.169	$.427	$1.340
OPTs	5% Year Sample	/4	/4	58.3%
		/5	/5	$.108
RHCs	5% Year Sample	/4	/4	57.7%
		/5	/5	$.096
ASCs	5% Year Sample	55.2%	23.3%	58.7%
		$.710	$.298	$.830
	IMPACT Act (Non-Add)	*$5.276*	*$5.293*	*$5.625*
Total Mandatory and Discretionary; State Direct Survey Cost (Medicare)/6		**$360.454**	**$363.158**	**$402.435**
Total; S&C Medicaid Grants to States		**$308.315**	**$286.750**	**$296.000**
Grand Total		**$668.769**	**$649.908**	**$698.435**

1/ Includes initial, recertification, and validation surveys
2/ Hospice surveys are partially funded by the IMPACT Act of 2015 PL 113-185 (SSA Sec. 1861(dd).
3/ Starting in FY 2021, surveys, certifications, and complaint investigation in psychiatric hospitals will be transitioned from being conducted by federal contractors to State Agencies.
4/ States will continue to respond to complaints, and based on availability of resources, conduct recertification surveys, and certify new facilities.
5/ Based on historical trends, CMS projects that States will allocate survey and certification funding from non-statutory facilities to fulfill requirements of statutory facilities.
/6 Due to rounding totals may not sum as displayed.

In FY 2021, CMS expects to complete approximately 29,538 initial and recertification inspections. In addition, CMS estimates 68,590 visits in response to complaints. The S&C Visit Tables below show that the majority of both surveys and complaint visits in FY 2021 are projected to be in nursing homes illustrating the challenges discussed in CMS' Initiative 1.

FY 2021 Survey and Complaint Visit Table - Projected

Provider Type	Facilities Beginning of Year	Recertification Validation Surveys	Initial Surveys	Complaint Visits	Total
Skilled Nursing Facility (SNF)	739	739	29	1,081	1,849
Skilled Nursing Facility/Nursing Facility (SNF/NF)	14,607	14,695	95	56,154	70,944
Nursing Facility (NF)	360	360	24	1,143	1,527
ICF/IID	6,002	6,002	75	3,898	9,975
Home Health Agency (HHA)	11,664	2,574	258	852	3,684
Hospices	4,749	892	259	314	1,465
Hospitals	6,144	137	56	3,329	3,522
Psychiatric Hospital	600	0	0	2	2
Transplant Hospitals	244	0	2	1,002	1,004
End Stage Renal Disease (ESRD)	7,356	1,559	325	655	2,539
Outpatient Therapy Center (OPT)	2,049	195	59	4	258
Comprehensive Outpatient Rehabilitation Facilities (CORF)	178	0	2	0	2
Portable X-Rays	490	0	16	1	17
Rural Health Centers (RHC)	4,351	15	199	34	248
Ambulatory Surgical Centers (ASC)	5,734	791	174	121	1,086
Community Mental Health Centers (CMHC)	140	0	6	0	6
Total	**65,407**	**27,959**	**1,579**	**68,590**	**98,128**

1/ Includes both Medicare and Medicaid certified and deemed facilities.
2/ A portion of hospice surveys are separately funded under the IMPACT Act PL 113-185.

- *Federal Direct Surveys*: $6.3 million. The FY 2021 Budget request for Federal Direct Surveys is $0.7 million below the FY 2020 Enacted level. The reduction reflects the transition of S&C activities for Psychiatric hospitals to State Agencies from federal contractors. In addition, in FY 2021 the level of effort for targeted and compliance performance surveys are lower than estimated in prior years. Funding for these projects were reduced to support funding in State Direct Surveys.

- *Support Contracts and IT*: $33.5 million. The FY 2021 Budget request for Support contracts and IT is $7.8 million above the FY 2020 Enacted level.

Proposed Law – Survey and Certification

CMS' FY 2021 Budget includes three legislative proposals:

1. ***Charge Long-Term Care Facilities Fees for Revisit Surveys.*** To incentivize facilities to restore and maintain compliance with Medicare COPs, CMS is proposing a mandatory revisit user fee proposal. This proposal provides CMS authority to charge long-term care facilities fees for any revisits required to validate the correction of deficiencies identified during initial certification, recertification, complaint, facility-reported incident, or prior revisit surveys. The Budget assumes that collections will not start until FY 2022. The collections will supplement Program Management funding for the Survey and Certification program and fees would be reduced for low-income and rural providers. Fees would not be levied upon Indian Health Service (IHS) facilities. CMS levied a similar revisit user fee in FY 2007, exhibiting the feasibility of such a fee.

2. ***Tailor the Frequency of Skilled Nursing Facility Surveys to More Efficiently Use Resources and Alleviate Burden for Top Performing Nursing Homes.*** To reduce provider burden and make funding to states more efficient, CMS is re-proposing a risk-based nursing home survey process. The risk-based nursing home survey would allow CMS to adjust Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) survey frequencies for top-performing nursing homes, not to exceed 10 percent of all Medicare or Medicaid-participating nursing homes in each State in any Federal fiscal year. Top-performing nursing homes would be required to be surveyed on average every 30 months (rather than the current 12 months) with no more than 36 months between recertification surveys of any single facility (compared to the current 15 month individual facility limit). CMS will reinvest all savings resulting from this change to strengthen oversight and quality improvement for Special Focus Facilities and other low performing facilities in an effort to focus additional resources where they are most needed to improve quality and promote patient safety.

3. ***Provide the Survey and Certification Program two-year period of availability.*** To improve CMS' administrative flexibility with respect to fund State Survey Agencies and contractors, CMS proposes two-year budget authority for the Survey and Certification program.

Clinical Laboratory Improvement Amendments of 1988 (CLIA)

The CLIA program is entirely funded by user fees that are charged to the laboratories regulated by the program. The FY 2021 Budget projection for CLIA is $66.4 million in user fee collections, which is an increase from FY 2020 by $1.5 million.

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) established quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed and to extend beyond Medicare and Medicaid. These outcomes are determined by on-site inspections of CLIA-identified laboratories. CMS works with SAs and AOs who perform inspections to ensure CLIA policies and procedures are followed.

CLIA laboratories are defined as any entity which conducts testing on human specimens for health purposes. CLIA laboratories can include traditional laboratories, hospitals, physician office laboratories, ambulatory surgical centers, rural health clinics, insurance laboratories, Federal, State, city/county laboratories, and community health screenings. CLIA provisions are based on the complexity of performed tests, as defined by the Food and Drug Administration (FDA). Along with the FDA, CMS also has inter-agency agreements with the Centers for Disease Control (CDC) to define quality and safety standards. Laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other sites. The more complex the tests performed, the more stringent the requirements.

The CLIA program approves Laboratory AOs such as the Joint Commission and the College of American Pathologists (CAP) as deeming organizations for certification of CLIA testing. AOs must meet the minimum CLIA regulations but can also be more stringent than CMS defined requirements. Laboratories which are accredited or which operate in exempt States are inspected by an AO or SA every two years.

Inspection of these laboratories by CMS or by an approved agent applies to all certificate types. Laboratories must allow access in order to assess compliance with requirements and must provide all information required to determine compliance. Failure to permit a survey will result in adverse action by CMS. The CMS survey process is outcome-oriented and utilizes an educational approach to assess compliance.

Number of Laboratories Subject to CLIA Oversight

Lab Type	FY2015 Actual	FY2016 Actual	FY2017 Actual	FY2018 Actual	FY2019 Final	FY2020 Enacted	FY2021 President's Budget
Compliance Labs	18,684	18,344	18,064	17,883	17,717	17,404	17,404
Accredited Labs	16,129	16,430	16,394	16,311	16,035	15,746	15,746
Waived Labs[/1]	166,959	173,121	176,019	178,616	184,458	189,410	189,410
PPMP[/1]	36,512	35,329	34,684	33,411	32,578	31,254	31,254
Total No. of Labs	**238,284**	**243,224**	**245,161**	**246,221**	**250,788**	**253,814**	**253,814**

1/ Waived and Provider Performed Microscopy Procedure (PPMP labs) are excluded and exempt from routine surveys, but are subject to announced or unannounced surveys under certain circumstances (i.e., complaints).

The following table shows the projected and actual number of labs surveyed, certified, and investigated from FY 2015 to FY 2021.

Projected Workloads	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Recertification/Initial of Compliance Labs	9,342	9,172	9,032	8,942	8,859	8,702	8,702
Complaint/Follow-ups of Compliance Labs	654	642	632	626	620	394	394
Validation Surveys of Accredited labs	403	411	410	408	401	609	609
Complaint/Follow-ups of Accredited Labs	28	29	29	28	28	27	27
Total Number of Projected Workloads	**10,427**	**10,254**	**10,103**	**10,004**	**9,908**	**9,732**	**9,732**
Actual Workloads							
Initial Surveys	1,282	1,188	1,143	1,272	TBD	TBD	TBD
Recertification	8,390	6,956	8,038	7,585	TBD	TBD	TBD
Validation	360	328	361	329	TBD	TBD	TBD
Complaints	175	191	330	307	TBD	TBD	TBD
Follow-Ups	987	904	1,258	626	TBD	TBD	TBD
Total Workload Completed	**11,194**	**9,567**	**11,130**	**10,119**	TBD	TBD	TBD

Grants to States Mandatory Appropriation: $296.0 million

The FY 2021 mandatory appropriation for the Grants to States for Medicaid is $296.0 million, $9.0 million above FY 2020. This funding will allow States to conduct surveys, certifications, and investigations of Medicaid eligible facilities. With this funding, CMS projects to meet all statutory requirements of the S&C program, including response to complaints and adherence to statutorily required survey frequencies.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Grants to States for Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$273,188,478,000] *$313,904,098,000,* to remain available until expended.

[For making,] *In addition, for carrying out such titles* after May 31, [2020, payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] *2021,* for the last quarter of fiscal year [2020] *2021* for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, *to remain available until expended.*

[For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act]. *In addition, for carrying out such titles* for the first quarter of fiscal year [2021] *2022*, [$139,903,075,000] *$148,732,315,000,* to remain available until expended.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

Grants to States for Medicaid

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, *[$273,188,478,000] $313,904,098,000,* to remain available until expended.	This section provides a no-year appropriation for Medicaid for FY 2021. This appropriation is in addition to the advance appropriation of $139.9 billion for the first quarter of FY 2021. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers.
[For making,] *In addition, for carrying out such titles after May 31, [2020, payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] 2021,* for the last quarter of fiscal year *[2020] 2021*, for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, *to remain available until expended.*	This section provides indefinite authority for payments to states in the last quarter of FY 2021 to meet unanticipated costs for carrying out titles XI and XIX, including the costs of the Vaccines for Children program. "For carrying out" is substituted for consistency throughout the appropriations language. "To remain available until expended" is included for alignment with other Medicaid appropriations provided in this language.

Grants to States for Medicaid

Language Analysis

Language Provision	Explanation
[For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] *In addition, for carrying out such titles* for the first quarter of fiscal year [2021] *2022, [$139,903,075,000] $148,732,315,000,* to remain available until expended.	This section provides an advance appropriation for the first quarter of FY 2022 to ensure continuity of funding for activities authorized under titles XI and XIX. This allows the Medicaid program, including the Vaccines for Children program, to continue operating in the event a regular appropriation for FY 2022 is not enacted by October 1, 2021. "For carrying out" is substituted for consistency throughout the appropriations language.
Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.	This section makes clear that funds are available with respect to state plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

Grants to States for Medicaid
Amounts Available for Obligation

(Dollars in Thousands)

	FY 2019 Actual	FY 2020 Est.	FY 2021 Est.	FY 2021 +/- FY 2020
Mandatory Appropriation:				
Advanced Appropriation.....	$134,847,759	$137,931,797	$139,903,075	$1,971,278
Annual Appropriation.....	$276,236,212	$273,188,478	$313,904,098	$40,715,620
Indefinite Annual Appropriation..	$0	$11,054,748	$0	($11,054,748)
Subtotal, Mandatory Appropriation	$411,083,971	$422,175,023	$453,807,174	$31,632,151
Offsetting Collections from Federal Sources:				
Collection Authority: Medicare Part D……..	$0	$0	$5,000	$5,000
Collection Authority: Medicare Part B……..	$1,182,645	$1,142,000	$1,249,000	$107,000
Subtotal, Collections Authority	$1,182,645	$1,142,000	$1,254,000	$112,000
Total New Budget Authority	**$412,266,616**	**$423,317,023**	**$455,061,174**	**$31,744,151**
Unobligated Balances:				
Unobligated balance, Start of year.....	$15,402,641	$14,678,963	$0	($14,678,963)
Unobligated balance, Recoveries of Prior Year Obligations (Unpaid)……	$34,290,280	$37,147,000	$38,208,071	$1,061,071
Recoveries of Prior Year Obligations (Paid)…….	$10,932,480			
Subtotal, Unobligated Balances.....	$60,625,401	$51,825,963	$38,208,071	($13,617,892)
Total Budgatary Resouraces (Amounts Available for Obligation)	**$472,892,017**	**$475,142,986**	**$493,269,244**	**$18,126,258**
Unobligated balance, end of year……..	$14,678,963	$0	$0	$0
Total, Gross Obligations.....	**$458,213,054**	**$475,142,986**	**$493,269,244**	**$18,126,258**
Net Obligations:				
Gross Obligations.....	$458,213,054	$475,142,986	$493,269,244	$18,126,258
Actual Collections: Medicare Part D……..	$0	$0	($5,000)	($5,000)
Actual Collections: Medicare Part B……..	($1,182,645)	($1,142,000)	($1,249,000)	($107,000)
Unobligated balance, Start of year.....	($15,402,641)	($14,678,963)	$0	$14,678,963
Unobligated balance, Recoveries of Unpaid Obligations.....	($34,290,280)	($37,147,000)	($38,208,071)	($1,061,071)
Total Net Obligations	**$407,337,488**	**$422,175,023**	**$453,807,174**	**$31,632,151**

Grants to States for Medicaid
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	Appropriation
2012	$270,724,399,000	$270,724,399,000
2013/1	$269,405,279,000	$269,405,279,000
2014/2	$284,208,616,000	$305,843,467,000
2015/3	$338,081,239,000	$368,405,940,000
2016/4	$356,817,550,000	$366,672,257,000
2017/5	$377,586,469,000	$389,349,760,000
2018	$410,017,836,000	$410,017,836,000
2019	$411,083,971,000	$411,083,971,000
2020/6	$411,120,275,000	$422,175,023,000
2021	$453,807,174,000	---

1/ Full-year continuing resolution appropriation provided indefinite funding authority of $158.8 billion for FY 2013.
2/ Includes $21.6 billion in indefinite funding authority obligated during FY 2014.
3/ Includes $16.8 billion in indefinite funding authority obligated during FY 2015.
4/ Includes $9.9 billion in indefinite funding authority obligated during FY 2016.
5/ Includes $11.8 billion in indefinite funding authority obligated during FY 2017.
6/ Includes $11.1 billion in indefinite funding authority estimated to be obligated during FY 2020.

Grants to States for Medicaid
Budget Authority by Object
(Dollars in Thousands)

	FY 2020 President's Budget	FY 2021 Estimate	FY 2021 +/- FY 2020
CMS - Grants to States			
Grants to States, Subsidies	$418,899,332	$450,109,804	$31,210,472
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$4,417,691	$4,951,369	$533,678
Total Budget Authority	**$423,317,023**	**$455,061,174**	**$31,744,151**

Grants to States for Medicaid
Budget Authority by Program Activity
(Dollars in Thousands)

	FY 2019 Actual	FY 2020 President's Budget	FY 2021 Estimate	FY 2021 +/- FY 2020
1. Medical Assistance Payments				
Medical Assistance Payments.....	$385,015,346	$358,351,658	$386,703,517	$28,351,859
Benefits Due and Payable (IBNR)	$0	$38,208,071	$40,237,652	$2,029,581
Subtotal, Benefits	**$385,015,346**	**$396,559,729**	**$426,941,169**	**$30,381,440**
2. Vaccine for Children				
Vaccines for Children.....	$4,160,865	$4,417,691	$4,951,369	$533,678
Subtotal, Vaccine for Children	**$4,160,865**	**$4,417,691**	**$4,951,369**	**$533,678**
3. State Administration				
State and Local Administration.....	$21,174,058	$20,620,000	$21,259,000	$639,000
HIT- Incentives.....	$0	$0	$0	$0
HIT- Provider.....	$800,004	$152,000	$80,000	($72,000)
HIT- Administration.....	$568,121	$990,853	$1,233,636	$242,783
State Survey and Certification.....	$277,472	$286,750	$297,000	$10,250
State Fraud Control Units.....	$270,750	$290,000	$299,000	$9,000
Subtotal, State Administration	**$23,090,405**	**$22,339,603**	**$23,168,636**	**$829,033**
Total Mandatory Appropriation……..	$411,083,971	$422,175,023	$453,807,174	$31,632,151
Total Offsetting Collection Authority[1,2]……..	$1,182,645	$1,142,000	$1,254,000	$112,000
Total, Budget Authority	**$412,266,616**	**$423,317,023**	**$455,061,174**	**$31,744,151**

1/ Budget authority authorized and appropriated through offsetting collection authority under Social Security Act, title XIX, Section 1933(f).
2/ Budget authority authorized and appropriated through offsetting collection authority under Social Security Act, title XVIII, 1860D-16(b)(2).

Authorizing Legislation - Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152
FY 2019 Authorization - Public Laws 115-141 and 115-245
FY 2020 Authorization – Public Law 116-94

Allocation Method - Formula Grants

Grants to States for Medicaid
Appropriated Budget Request[1]

(Dollars in Thousands)

	FY 2019 President's Budget	FY 2020 President's Budget	FY 2021 President's Budget	FY 2021 +/- FY 2020
Program Activity				
Medical Assistance Payments.....	$383,832,701	$395,417,729	$425,687,169	$30,269,440
State and Local Administration.....	$23,090,405	$22,339,603	$23,168,636	$829,033
Vaccine for Children.....	$4,160,865	$4,417,691	$4,951,369	$533,678
Subtotal, Medicaid Program Level	**$411,083,971**	**$422,175,023**	**$453,807,174**	$31,632,151
Less funds advanced in prior year.	$134,847,759	$137,931,797	$139,903,075	$1,971,278
Total, Grants to States for Medicaid	**$276,236,212**	**$273,188,478**	**$313,904,098**	$40,715,620
New advance 1st quarter of subsequent FY.....	$137,931,797	$139,903,075	$148,732,315	$8,829,240

1/ Funding represented in the chart equals the respective President's budget requests. FY 2020 does not include $11.1 billion in indefinite funding authority estimated to be obligated during FY 2020.

Grants to States for Medicaid

Authorized under title XIX of the Social Security Act, Medicaid provides health coverage for millions of America's most vulnerable populations, including low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other eligible adults. In addition, Medicaid provides home and community-based services and support to seniors and individuals with disabilities, as well as institutional long-term care services. Medicaid is administered by CMS in partnership with the states.

The table below, and the following language, provides additional detail on each of the Grants to States for Medicaid program activities for FY 2021.

Summary of Request
Grants to States for Medicaid Mandatory Appropriation Request Summary Table
(Dollars in Millions)

Program Activity	FY 2019 Actual	FY 2020 Enacted	FY 2021 Estimate	FY 2021 +/- FY 2020
Medical Assistance Payments	$383,833	$395,417	$425,687	$30,270
State and Local Administration	$23,090	$22,340	$23,169	$829
Vaccine for Children	$4,161	$4,418	$4,951	$533
Total Mandatory Appropriation Request[1]	**$411,084**	**$422,175**	**$453,807**	**$31,632**

1/ Numbers may not add due to rounding.

FY 2021 Mandatory Appropriation Request: $453.8 billion

CMS' FY 2021 mandatory appropriation request for the Grants to States for Medicaid account is $453.8 billion, an increase of $31.6 million relative to the FY 2020 request level of $422.2 billion. This appropriation is composed of $139.9 billion in an authorized advance appropriation for FY 2021 and a remaining appropriation of $313.9 billion for FY 2021.

Resources will help fund $493.3 billion in anticipated FY 2021 Medicaid obligations. CMS also anticipates carryover balances and recoveries in the amount of $38.2 billion as well as budget authority from offsetting collections from the Supplementary Medical Insurance trust fund and Medicare Part D account in the amount of $1.3 billion to fund the remaining anticipated obligations. These estimated obligations include:

- $465.1 billion in Medicaid medical assistance payments (MAP);
- $23.2 billion for Medicaid state and local administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $5.0 billion for the Centers for Disease Control and Prevention's Vaccines for Children (VFC) program.

This submission is based on projections from state-submitted estimates and CMS using Medicaid expenditure data as recent as the third quarter of FY 2019. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2021 President's Budget.

Under current law, the federal share of Medicaid net outlays is estimated to be $ $451.8 billion in FY 2021. This represents an increase of 1.0 percent relative to the estimated net outlay level of $447.2 billion for FY 2020.

The FY 2021 estimate will be discussed in further detail by the major program activities of the Grants to States for Medicaid account; Medical Assistance Payments, Vaccines for Children, and State and Local Administration.

Grants to States for Medicaid

Medical Assistance Payments

(Dollars in Thousands)

	FY 2019 Enacted	FY 2020 Estimate	FY 2021 Estimate	FY 2021 +/- FY 2020
Medical Assistance Payments	$383,832,701	$395,417,729	$425,687,169	$30,269,440

Program Activity Description and Accomplishments

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's low-income population.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one State may not be eligible in another State, and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, State legislatures may change Medicaid eligibility, benefits, and/or reimbursement, subject to federal standards, at any time.

Medicaid payments are made directly by states to health care providers or health plans for services rendered to beneficiaries. Providers must accept the state's payment as full reimbursement. By law, Medicaid is generally the payer of last resort. If other parties, including Medicare, are legally liable for services provided to a Medicaid beneficiary, that party generally must first meet its financial obligation before Medicaid payment is made.

Medicaid Eligibility and Enrollment

Medicaid provides health coverage for millions of America's most vulnerable populations, including low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other eligible adults.

The following table reflects the estimated annual Medicaid enrollment in number of person-years, which represents full-year equivalent enrollment. It is based on the 56 jurisdictions in the program.

Medicaid Enrollment (Person-Years in Millions)[1]

	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate	FY 2021 +/- FY 2020
Aged	6.1	6.3	6.4	0.2
Disabled	10.2	10.2	10.3	0.0
Adults	27.3	27.2	27.3	0.1
Children	28.9	28.5	28.5	0.0
Territories	1.4	1.4	1.4	0.0
Total[1]	**73.9**	**73.6**	**74.0**	**0.3**

1/ Totals do not add due to rounding.

According to CMS projections of Medicaid enrollment, 74.0 million Americans will be enrolled in Medicaid for the equivalent of a full year during FY 2021. In FY 2021, Medicaid is projected to provide coverage to more than one out of every five people in the nation. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 0.4 percent in FY 2021 from the estimated FY 2020 enrollment level.

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans. However, a state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Pregnancy-related services, including prenatal care and 60 days postpartum pregnancy-related services.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive federal matching funds to provide certain optional services. Following are some of the most common, currently approved optional Medicaid services:

- Diagnostic services.
- Clinic services.
- Intermediate care facility services.

- Prescribed drugs and prosthetic devices.
- Optometrist services and eyeglasses.
- Nursing facility services for children under age 21.
- Rehabilitation and physical therapy services.
- Hospice care.
- Home and community-based care to certain persons with chronic impairments.
- Targeted case management services.

FY 2021 Estimate

Budget Estimate: $425.7 Billion

CMS' Medical Assistance Payments (MAP) budget estimate is $425.7 billion, a $30.3 billion increase above the FY 2020 estimated level. The following language provides additional detail on CMS' FY 2021 estimate: In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to reflect actuarial estimates developed by CMS' Office of the Actuary (OACT), legislative and regulatory impacts, entitlement benefits due and payable, CMS financial management reviews and estimates of expenditure transfer authority from the Medicare trust funds.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

CMS' OACT has found that state-submitted estimates of the grant awards tend to be higher than actual expenditures and, because of this, CMS' OACT relies more on actual expenditure data than the state-submitted estimates. CMS' OACT developed the MAP estimate for FY 2021 using the three quarters of FY 2019 state-reported expenditures as a base. Expenditures for FY 2019, FY 2020, and FY 2021 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by OMB and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the state-submitted estimates.

For an in-depth analysis of the actuarial Medicaid cost estimates and financial outlook on the Medicaid program, see the Actuarial Report on the Financial Outlook for Medicaid.

Entitlement Benefits Due and Payable (Incurred but not Reported)

The FY 2021 estimate of $40.2 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2020 to September 30, 2021. This Medicaid liability is developed from estimates received from the states. The incurred but not reported estimate represents the net of unreported expenses incurred by the states less amounts owed to the states for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

Transfer from the Supplementary Medical Insurance Trust Fund for Qualified Individuals

Social Security Act Title XIX Section 1933(f) authorizes a transfer from the Supplementary Medical Insurance Trust Fund to the Grants to States for Medicaid account to account for the Medicare programs costs attributable to state coverage of Medicare cost-sharing for certain low-income Medicare beneficiaries. This estimate is developed by CMS' OACT,

which for FY 2021 is estimated to be $1.3 billion. This transfer of funding is used to offset MAP obligations, thereby reducing the overall mandatory appropriation request.

Legislative and Regulatory Impacts to the Medicaid Baseline

In addition to adjusting the state estimates, CMS' OACT also estimates the impact of recent legislative and regulatory actions. Below is a list of select recent actions that impacted the current actuarial baseline estimate.

Legislative Actions

SUPPORT for Patients and Communities Act of 2018 (P.L. 115-271)

This Act contains a number of Medicaid provisions related to coverage and services for beneficiaries with substance use disorders.

Medicaid Extenders Act of 2019 (P.L. 116-3)

This law includes extensions of Money Follows the Person program and spousal impoverishment rules, and reduces the federal match for states that have not implemented asset verification programs.

Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16)

This law temporarily extends the applicability of Medicaid eligibility criteria that protect against spousal impoverishment for recipients of home- and community-based services.

The law also establishes a state Medicaid option to provide for medical assistance with respect to coordinated care provided through a health home (i.e., a designated provider or team of health-care professionals) for children with medically complex conditions. States must determine payment methodologies in accordance with specified requirements; payments also temporarily qualify for an enhanced federal matching rate.

Further, drug manufacturers with Medicaid rebate agreements for covered outpatient drugs must disclose drug product information. Manufacturers are subject to civil penalties for knowingly misclassifying drugs. Manufacturers are also required to compensate for rebates that were initially underpaid because of misclassification (whether or not such misclassification was committed knowingly).

National Defense Authorization Act for Fiscal Year 2020 (P.L. 116-92)

This law extends the Afghan special immigrant visa (SIV) program and provides an adjustment for Liberian nationals. Both groups are eligible for Medicaid benefits.

Further Consolidated Appropriations Act of 2020 (P.L. 116-94)

This Act extends Sec. 223 grants, provides additional funding for territories, and repealed the health insurance provider tax.

Regulatory Actions

SMDL #18-002: Opportunities to promote work and community engagement among Medicaid beneficiaries

This SMDL informed states of an opportunity to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility or coverage for certain adult Medicaid beneficiaries in demonstration projects authorized under section 1115 of the Social Security Act.

SMDL #18-005: Phase-out of expenditure authority for Designated State Health Programs (DSHP) in section 1115 demonstrations

This SMDL informed states that CMS would no longer accept state proposals for new or renewing section 1115 demonstrations that rely on federal matching funds for designated state health programs (DSHP) that were previously funded entirely by the state.

Administrative Proposals Assumed in the FY 2021 President's Budget

- Require minimum standards in Medicaid state drug utilization review programs (CMS-2482-P)
- Improve Transparency and Accountability of Medicaid Financing and Supplemental Payments (CMS-2393-P)
- Make Medicaid non-emergency medical transportation optional (CMS-2481-NC)
- Strengthen Medicaid eligibility process program integrity (CMS-2421-P)
- Address Medicaid payments to States for ineligible beneficiaries (CMS-6083-P)
- Reduce the Federal Match Rate for Medicaid Eligibility Workers

Please see the FY 2021 HHS Budget-in-Brief for more detail on legislative and administrative proposals for Medicaid.

Grants to States for Medicaid

Vaccines for Children

(Dollars in Thousands)

	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate	FY 2021 +/- FY2020
Vaccines for Children	$4,160,865	$4,417,691	$4,951,369	$533,678

Program Activity Description and Accomplishments

The Vaccines for Children (VFC) program is 100 percent federally funded by the Medicaid appropriation and operated by the Centers for Disease Control and Prevention. This program allows vulnerable children access to lifesaving vaccines as a part of routine preventive care, focusing on children without insurance, those eligible for Medicaid, and American Indian/Alaska Native children. Children with commercial insurance that lack an immunization benefit are also entitled to VFC vaccine, but only at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). To reach eligible children under the VFC program, federally purchased vaccines are distributed to public health clinics and enrolled private providers. Through VFC, the Centers for Disease Control and Prevention provides funding to 61 state and local public health immunization programs that include all 50 states, six city/urban areas, and five U.S. territories and protectorates.

The nation's childhood immunization coverage rates are at high levels for most vaccines and vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine-preventable diseases (VPDs) decline significantly. Vaccination against diphtheria, *haemophilus influenza* type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella is recommended. In addition to the health benefits of immunization, vaccines also provide significant economic value. Millions of children have benefited from vaccination since the Vaccines for Children Program began in 1994. Among children born during 1994–2016, vaccination will prevent an estimated 388.0 million illnesses, 24.5 million hospitalizations, and 855,000 early deaths over the course of their lifetimes, at a net savings of $360 billion in direct costs and $1.65 trillion in total societal costs.[1]

FY 2021 Budget Estimate: $5.0billion

CMS' Vaccine for Children estimate is $5.0 billion, a $533.7 million increase over the FY 2020 estimated level.

This estimate includes an increase for vaccine-purchase contract costs and additional quality assurance and quality improvement site visits to VFC-enrolled providers. This budget will ensure sufficient quantities of pediatric vaccines are available to immunize VFC eligible children; approximately 96 percent of the VFC budget are used to purchase vaccines, including vaccine purchases for the VFC stockpile. The VFC stockpile is a

[1] https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6316a4.htm?s_cid=mm6316a4_w

strategic asset for the nation's immunization system that is used to fight outbreaks of VPDs and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports vaccine ordering and distribution, including costs of ordering vaccines on behalf of states, immunization coverage surveys, and program support and oversight.

Grants to States for Medicaid

State and Local Administration

(Dollars in Thousands)

	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate	FY 2021 +/- FY 2020
State and Local Administration	$23,090,405	$22,339,603	$23,168,636	$829,033

Program Activity Description and Accomplishments

State and Local Administration

State and Local Administration funding includes Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems; non-MMIS automated data processing activities; skilled professional medical personnel (SPMP); salaries, fringe benefits, and training; and other state and local administrative costs. These other costs include quality improvement organizations, pre-admission screening and resident review, nurse aide training and competency evaluation programs, and all other general administrative costs.

Medicaid Survey and Certification

The Medicaid survey and certification inspection program for nursing facilities, home health agencies and intermediate care facilities for individuals with intellectual disabilities ensures that Medicaid beneficiaries are receiving quality care in a safe environment. In order to secure quality care for the nation's most vulnerable populations, CMS requires that certain facilities seeking participation in Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with state survey agencies in each of the 50 states, the District of Columbia, Puerto Rico, and two other territories. Utilizing more than 7,500 surveyors across the country, state survey agencies inspect providers and determine their compliance with specific federal health, safety, and quality standards.

Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as neglect or abuse of patients in health care facilities and board and care facilities. The MFCUs are typically a part of the state Attorney General's office or have arrangements with the Attorney General or another office with statewide prosecutorial authority. In FY 2018, MFCUs were responsible for 1,503 convictions, 810 civil settlements, and expected monetary recoveries for both civil and criminal cases of $859 million. MFCU cases in FY 2018 were also responsible for the exclusion of 974 individuals and entities from participation in Medicaid and other federally funded health care programs.

Health Information Technology Meaningful Use Incentive Program

The American Recovery and Reinvestment Act of 2009 (ARRA) authorizes Medicaid to provide incentive payments to doctors, hospitals, and other providers for the implementation and meaningful use of certified EHRs. The provision allows for enhanced federal financial participation (FFP) of 100 percent for incentive payments to providers for the purchase, maintenance, and meaningful use of certified EHRs, and 90 percent FFP for state and local administrative expenses associated with administering the incentive payments.

FY 2021 Budget Estimate: $23.2 Billion

CMS' State Administration estimate is $23.2 billion; an $829.0 million dollar increase over the FY 2020 estimated level.

This estimate is composed of $297.0 million for Medicaid state survey and certification, $299 million for state Medicaid Fraud Control Units, $1.3 billion for the Health Information Technology Meaningful Use Incentive Program, and $21.3 billion for other Medicaid state and local administration. The estimate is also reduced by the estimated expenditure transfer authority from the Medicare Part D account for state low income determinations.

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities home health agencies and intermediate care facilities for individuals with intellectual disabilities in FY 2021 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2021 estimate for Medicaid state survey and certification is $297.0 million. This represents an increase of over $10.2 million above the FY 2020 estimated amount of $286.8 million. This funding level supports increasing workload requirements (i.e., increases in the average hours per survey) and labor costs; costs associated with survey and certification activities covering over 33,500 Medicaid participating facilities with nearly 24,500 health and life safety code annual certifications, as well as over 55,800 complaint survey investigations; and direct state survey costs associated with nursing home and home health agency quality.

Medicaid Fraud Control Units

In FY 2021, MFCUs in 53 states and territories will investigate and prosecute Medicaid providers and protect beneficiaries from patient abuse or neglect. These operations are currently estimated to total $299.0 million. This represents an increase of $9.0 million over the FY 2020 estimate of $290.0 million. The estimated increase is because of a small net increase to staff and related expenses for the existing MFCUs, as well as the addition of new MFCUs in North Dakota, Puerto Rico, and the U.S. Virgin Islands. The MFCUs' mission is to investigate and prosecute provider fraud in state Medicaid programs as well as patient abuse and neglect in health care facilities. In FY 2018, states reported $859 million in expected recoveries for both civil and criminal cases handled by the 50 MFCUs operating that year.

Health Information Technology Meaningful Use Incentive Program

The current FY 2021 estimate for the provider incentives payments and state administrative costs is $1.3 billion. These incentives continue to encourage adoption and meaningful use of electronic health records (EHRs). As providers have utilized the incentive payments to enhance their EHRs, states are seeing an increase in the need for ways to securely share these records among health care providers. States are committed to supporting this and other initiatives like the Electronic health information exchange (HIE), which allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

Transfer from the Medicare Part D account for State Low Income Determinations

The current FY 2021 estimate for this transfer is $5.0 million, an increase of $5.0 million from the FY 2020 estimate. Social Security Act Title XVIII Section 1860D-16(b)(2) authorizes a transfer from the Medicare Part D account to the Grants to States for Medicaid account to account for state administrative costs relating to Medicare prescription drug low-income subsidies, Medicare transitional prescription drug assistance, and Medicare cost-sharing. This amount is determined by CMS using actual state-submitted expenditure data projected into FY 2021.

All Other Medicaid State and Local Administration

The CMS estimate for FY 2021 is $21.3 billion. CMS adjusted the FY 2020 state-submitted estimates of $20.6 billion upward to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when states submitted estimates.

FY 2021 MANDATORY STATE/FORMULA GRANTS[1,2,3]

(Dollars in Thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2019 Obligations	FY 2020 Estimate[3]	FY 2021 Estimate[3]	Difference +/- 2021
Alabama	$4,374,830	$4,798,073	$5,063,654	$265,581
Alaska	$1,627,974	$1,775,359	$1,858,131	$82,772
Arizona	$10,318,779	$10,727,829	$11,535,020	$807,191
Arkansas	$5,502,868	$5,616,522	$5,836,993	$220,471
California[1]	$56,720,417	$63,728,887	$62,481,378	-$1,247,509
Colorado	$5,521,554	$5,796,624	$5,809,471	$12,847
Connecticut	$5,058,411	$5,296,308	$5,259,989	-$36,319
Delaware	$1,528,039	$1,641,294	$1,710,698	$69,404
Dist. Of Col.	$2,273,815	$2,325,170	$2,480,719	$155,549
Florida	$15,301,471	$16,799,910	$17,486,983	$687,073
Georgia	$7,725,952	$7,961,297	$8,118,467	$157,170
Hawaii	$1,466,754	$1,426,259	$1,367,397	-$58,862
Idaho	$1,604,141	$2,011,388	$2,102,862	$91,474
Illinois	$11,498,126	$12,152,340	$12,186,178	$33,838
Indiana	$9,240,467	$11,367,527	$10,651,426	-$716,101
Iowa	$3,541,669	$4,064,129	$3,916,162	-$147,967
Kansas	$2,189,481	$2,540,713	$3,275,466	$734,753
Kentucky	$8,175,973	$9,569,819	$9,836,286	$266,467
Louisiana	$8,697,690	$9,607,932	$9,991,889	$383,957
Maine	$1,988,688	$2,402,792	$2,421,340	$18,548
Maryland	$7,407,719	$7,391,491	$7,478,728	$87,237
Massachusetts	$10,386,402	$11,586,231	$11,633,981	$47,750
Michigan	$13,476,324	$14,205,599	$14,731,321	$525,722
Minnesota	$7,701,626	$8,683,394	$8,841,522	$158,128
Mississippi	$4,330,970	$4,535,154	$4,755,553	$220,399
Missouri	$7,188,633	$7,459,768	$7,595,079	$135,311
Montana	$1,506,199	$1,570,847	$1,636,887	$66,040
Nebraska	$1,217,420	$1,382,149	$1,798,757	$416,608
Nevada	$3,083,534	$3,201,992	$3,094,560	-$107,432
New Hampshire	$1,198,947	$1,285,310	$1,316,099	$30,789
New Jersey	$9,953,431	$10,324,962	$10,681,302	$356,340
New Mexico	$4,303,472	$5,234,838	$5,410,986	$176,148
New York	$42,373,210	$47,759,237	$48,585,670	$826,433
North Carolina	$9,699,171	$10,511,204	$10,506,386	-$4,818
North Dakota	$779,781	$850,163	$873,554	$23,391
Ohio	$16,630,159	$18,138,259	$19,162,496	$1,024,237
Oklahoma	$3,195,905	$3,562,491	$3,853,418	$290,927
Oregon	$7,245,419	$8,011,013	$8,343,426	$332,413
Pennsylvania	$19,266,813	$21,162,686	$21,220,959	$58,273
Rhode Island	$1,678,591	$1,502,030	$1,555,711	$53,681
South Carolina	$4,747,256	$4,814,339	$4,752,604	-$61,735
South Dakota	$581,879	$649,467	$682,143	$32,676
Tennessee	$7,168,469	$8,312,257	$8,776,314	$464,057
Texas	$24,254,323	$26,384,397	$27,538,034	$1,153,637
Utah	$2,022,162	$2,245,857	$2,282,131	$36,274

State/Territory	FY 2019 Obligations	FY 2020 Estimate[3]	FY 2021 Estimate[3]	Difference +/- 2021
Vermont	$1,079,258	$1,109,055	$1,075,070	-$33,985
Virginia	$2,776,475	$9,554,161	$10,295,895	$741,734
Washington[1]	$6,517,016	$9,069,170	$9,069,170	$0
West Virginia	$3,225,046	$3,377,342	$3,551,649	$174,307
Wisconsin	$5,701,464	$5,939,841	$6,078,338	$138,497
Wyoming	$364,945	$389,711	$397,064	$7,353
Subtotal	**$395,419,120**	**$441,814,587**	**$450,965,316**	**$9,150,729**
Amer. Samoa[1,2]	$37,706	$84,000	$84,000	$0
Guam[2]	$111,385	$127,000	$127,000	$0
N. Mariana Islands[2]	$49,801	$60,000	$60,000	$0
Puerto Rico[2]	$2,645,565	$2,623,188	$2,719,072	$95,884
Virgin Islands[2]	$123,625	$126,000	$126,000	$0
Subtotal	**$2,968,082**	**$3,020,188**	**$3,116,072**	**$95,884**
Total States and Territories	**$398,387,202**	**$444,834,775**	**$454,081,388**	**$9,246,613**
Survey & Certification	$277,472	$286,750	$297,000	$10,250
Fraud Control Units	$270,750	$290,000	$299,000	$9,000
Vaccines For Children	$4,160,865	$4,417,691	$4,951,369	$533,678
Undistributed	$55,116,767	$25,313,771	$30,007,648	$4,693,877
Total Obligations	**$458,213,054**	**$475,142,987**	**$489,636,405**	**$5,246,805**

1/The FY 2019 actuals for CA, WA, and AS have not been certified by their respective States or territory. The amounts displayed are estimates.
2/The FY 2020 and 2021 estimates for the territories have been adjusted to account for the limitation on total Medicaid payments to each territory as defined by 42 U.S.C. 1308 as well as funding limitations provided under 42 U.S.C. 18043.
3/ Obligation estimates for FY 2020 and 2021 reflect the State reported estimates of Medicaid needs available to CMS in November 2019.

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Payments to the Health Care Trust Funds

Appropriations Language

For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g),1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, [$410,796,100,000]*$439,514,000,000.*

In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary*.*

Payments to the Health Care Trust Fund

Language Analysis

Language Provision	Explanation
For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, *$439,514,000,000.*	Provides a one-year appropriation from general revenues to make the HI and SMI Trust Funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and to provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.
In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.	Provides indefinite authority for paying the general revenue portion of the Part B premium match and for general fund resources for Part D prescription drug benefit payments in the event that the annual appropriation is insufficient.

Payments to the Health Care Trust Funds
Amounts Available for Obligation
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Appropriation: Annual	$378,343,800	$410,796,100	$439,514,000	$28,717,900
Indefinite Annual Appropriation, for SMI Premium Match	$0	$0	$0	$0
Indefinite Annual Appropriation, for Part D Benefits	$13,000,000	$0	$0	$0
Lapse in Supplemental Medical Insurance	$0	$0	$0	$0
Lapse in General Revenue Part D: Benefits	$0	$0	$0	$0
Lapse in General Revenue Part D: Federal Administration	$0	$0	$0	$0
Lapse in Program Management	$0	$0	$0	$0
Lapse in Transfer for HCFAC Reimbursement	$0	$0	$0	$0
Lapse in State Low Income Determination	$0	$0	$0	$0
Total Obligations	$391,343,800	$410,796,100	$439,514,000	$28,717,900

Payments to the Health Care Trust Funds
Summary of Changes

FY 2020 Enacted

Total Budget Authority - $410,796,100,000

FY 2021 President's Budget

Total Budget Authority - $439,514,000,000
Net Change, Total Appropriation - $28,717,900,000

Changes	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Federal Payment for Supplementary Medical Insurance (SMI)	$284,288,300,000	$304,044,600,000	$325,500,000,000	$21,455,400,000
Indefinite Annual Appropriation, SMI	$0	$0	$0	$0
Hospital Insurance for Uninsured Federal Annuitants	$127,000,000	$109,000,000	$95,000,000	($14,000,000)
Program Management Administrative Expenses	$898,000,000	$913,000,000	$904,000,000	($9,000,000)
General Revenue for Part D (Drug) Benefit	$92,070,000,000	$104,539,500,000	$111,800,000,000	$7,260,500,000
Indefinite Annual Appropriation, Part D Benefits	$13,000,000,000	$0	$0	$0
General Revenue for Part D Federal Administration	$642,000,000	$861,000,000	$882,000,000	$21,000,000
Part D: State Low-Income Determination	$3,500,000	$5,000,000	$5,000,000	$0
Reimbursement for HCFAC	$315,000,000	$324,000,000	$328,000,000	$4,000,000
Net Change	$391,343,800,000	$410,796,100,000	$439,514,000,000	$28,717,900,000

Payments to the Health Care Trust Funds
Budget Authority by Activity
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Supplementary Medical Insurance	$284,288,300	$304,044,600	$325,500,000	$21,455,400
Indefinite Annual Appropriation, SMI	$0	$0	$0	$0
Hospital Insurance for Uninsured Federal Annuitants	$127,000	$109,000	$95,000	($14,000)
Program Management Administrative Expenses	$898,000	$913,000	$904,000	($9,000)
General Revenue for Part D Benefit	$92,070,000	$104,539,500	$111,800,000	$7,260,500
Indefinite Annual Appropriation, Part D Benefits	$13,000,000	$0	$0	$0
General Revenue for Part D Federal Administration	$642,000	$861,000	$882,000	$21,000
Part D: State Low-Income Determination	$3,500	$5,000	$5,000	$0
Reimbursement for HCFAC	$315,000	$324,000	$328,000	$4,000
Total Budget Authority	$391,343,800	$410,796,100	$439,514,000	$28,717,900

Payments to the Health Care Trust Funds
Authorizing Legislation
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Payments to the Health Care Trust Funds (sections 217(g), 201(g), 1844, and 1860D-16 of the Social Security Act, section 103(c) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248)	$391,343,800	$410,796,100	$439,514,000	$28,717,900
Total Budget Authority	$391,343,800	$410,796,100	$439,514,000	$28,717,900

Annual Budget Authority by Activity

(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Budget Authority	$391,343,800	$410,796,100	$439,514,000	$28,717,900

Authorizing Legislation - Sections 217(g), 201(g), 1844 and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248.
Allocation Method - Direct federal/intramural

Program Description and Accomplishments

The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the general fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds to reimburse the trust funds for amounts to which they are entitled under law. These payments make the Medicare Trust Funds whole for certain costs, described below, initially borne by the trust funds which are properly charged to the General Fund under current law, including amounts due to the SMI Trust Fund for the General Fund contribution for the cost of the Part B and Part D programs.

Through this appropriation, the Trust Funds are made whole for:

Federal Contribution for SMI:

Federal Contribution for SMI consists of a federal match for premiums paid by or for individuals voluntarily enrolled in the SMI program, also referred to as Part B of Medicare. The Part B premium for all beneficiaries is generally set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries, including a sufficient contingency margin. The federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled beneficiaries.

The FY 2021 President's Budget request of $325.5 billion, is a net increase of $21.5 billion over the FY 2020 enacted amount of $304.0 billion. The cost of the federal match continues to rise from year to year because of beneficiary population and program cost growth.

Hospital Insurance for the Uninsured Federal Annuitants:

Hospital Insurance for Uninsured Federal Annuitants includes costs for civil service annuitants who earned coverage for Medicare under transitional provisions enacted when Medicare coverage was first extended to Federal employees.

The FY 2021 estimated request of $95.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $14.0 million from the FY 2020 estimated amount of $109.0 million. The Medicare-eligible retirees are no longer growing, therefore less funding is needed.

Program Management Administrative Expenses:

Program Management Administrative Expenses includes the portion of CMS' administrative costs, initially borne by the Hospital Insurance (HI) Trust Fund, which is properly chargeable to the general funds, e.g., federal administrative costs for the Medicaid program, and for Center for Consumer Information and Insurance Oversight (CCIIO) related activities.

The FY 2021 President's Budget request of $904.0 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare trust fund activities is a net decrease of $9.0 million from the FY 2020 Enacted amount of $913.0 billion. Administrative expense changes primarily represent the decrease in costs for the Exchanges.

General Revenue for Part D (Benefits) and Federal Administration:

The Medicare Prescription Drug Plan program was created as a result of the enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Beginning in FY 2006, the reimbursements through the Payments to the Health Care Trust Funds account include General Revenue for Part D (Benefits) and General Revenue for Part D Federal Administration. General fund payments to the SMI Trust Fund offset these Medicare Prescription Drug Account costs.

The FY 2021 President's Budget request of $111.8 billion for General Revenue for Part D (Benefits) is a net increase of $7.3 billion over the FY 2020 Enacted amount of $104.5 billion. The benefit contribution increases with Part D Prescription Drug program population and cost increases.

The FY 2021 President's Budget request of $882.0 million for General Revenue for Part D Federal Administration is a net increase of $21.0 million above the FY 2020 Enacted amount of $861.0 million.

The FY 2021 President's request for General Revenue for Part D State Eligibility Determinations remains at $5.0 million.

Reimbursement for HCFAC:

The Health Care Fraud and Abuse Control (HCFAC) account includes program integrity activities for Medicare, Medicare Advantage, Medicaid, the Children's Health Insurance Program, and the Federal Exchanges. The reimbursement includes that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the Hospital Insurance and Supplementary Medical Insurance Trust Funds, which are properly chargeable to the general fund.

The FY 2021 President's Budget request of $328.0 million for reimbursement of HCFAC is a net increase of $4.0 million above the FY 2020 Enacted amount of $324.0 million. This amount reflects an estimate of that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the HI and SMI Trust Funds, but which are properly chargeable to the general fund. The FY 2021 request reflects the estimated Medicare non-trust fund burdens only. This is based on the current allocation of HCFAC spending data for the above mentioned non-trust fund program integrity activities.

CMS and Social Security Administration (SSA) Cost-sharing Agreement Workgroup

The Social Security Administration's Limitation on Administrative Expenses (LAE) account is funded by the Social Security trust funds, the General Fund, the Medicare trust funds, and applicable user fees. Section 201(g) of the Social Security Act provides that SSA determine the share of administrative expenses that should have been borne by the appropriate trust funds for the administration of their respective programs and the General Fund for administration of the SSI program. SSA and CMS are currently working together to evaluate the cost-sharing agreement that determines the portion of administrative expenses borne by the SSA and Medicare trust funds and the general fund.

Funding History

The funding history for Payments to the Health Care Trust Funds is represented in the chart below:

Fiscal Year	Budget Authority
FY 2017	$328,187,700,000
FY 2018	$352,597,300,000
FY 2019	$391,343,800,000
FY 2020	$410,796,100,000
FY 2021	$439,514,000,000

Permanent Budget Authority
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Tax on OASDI Benefits	$24,686,000	$27,062,000	$29,300,000	$2,238,000
SECA Tax Credits	$0	$0	$0	$0
HCFAC, FBI	$138,344	$150,733	$138,344	($12,389)
HCFAC, Asset Forfeitures	$31,000	$32,000	$32,000	$0
HCFAC, Criminal Fines*	$150,000	$190,000	$36,464	($153,536)
HCFAC, Civil Penalties and Damages: Administration	$20,800	$22,000	$52,000	$30,000
Total Budget Authority	$25,026,144	$27,456,732	$29,558,808	$2,102,075

* The HCFAC, Criminal Fines estimates for FY2019 and FY2020 are based on 5 year averages of Criminal Fines collected. The actual collection during the last couple fiscal years have been greatly reduced. The FY2021 estimate does not use the five-year average, and reflects the actual collections from the last three fiscal years.

** The methodology for estimating the HCFAC, Criminal Fines was changed in FY2021 to more closely reflect that actuals in FY2017-2019. A comparison of FY2020/FY2021 is not appropriate.

Authorizing Legislation - Sections 1817(k) and 1860D-31 of the Social Security Act, and sections 121 and 124 of the Social Security Amendments Act of 1983.

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

A permanent indefinite appropriation of general funds for the taxation of Social Security benefits is made to the HI Trust Fund through the Payments to the Health Care Trust Funds account. Additionally, the following permanent indefinite appropriations associated with the Health Care Fraud and Abuse Control (HCFAC) account activities will pass through the Payments to the Health Care Trust Funds account: Federal Bureau of Investigation (FBI) funding, asset forfeitures, criminal fines, and the administrative costs of activities associated with civil penalties and damages (CP&D) collections. FBI and CP&D administrative funds address prosecution of health care matters, investigations, financial and performance audits, inspections, and other evaluations. Asset forfeitures and criminal fines are amounts collected from health care fraud activities, and are permanent indefinite appropriations from the general fund, transferred to the HI Trust Fund.

Payments to the Health Care Trust Funds
Budget Authority by Object
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 +/- FY 2020
Grants, subsidies and contributions: Non-Drug	$284,288,300	$304,044,600	$325,500,000	$21,455,400
Indefinite Annual Appropriation	$0	$0	$0	$0
Grants, subsidies and contributions: Drug	$92,070,000	$104,539,500	$111,800,000	$7,260,500
Indefinite Annual Appropriation, Part D Benefits	$13,000,000	$0	$0	$0
Insurance claims and indemnities	$127,000	$109,000	$95,000	($14,000)
Administrative costs-General Fund Share	$1,855,000	$2,098,000	$2,114,000	$16,000
General Revenue Part D: State Eligibility Determinations	$3,500	$5,000	$5,000	$0
Total Budget Authority	$391,343,800	$410,796,100	$439,514,000	$28,717,900

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Table of Contents

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Appropriations Language

Centers for Medicare & Medicaid Services

Health Care Fraud and Abuse Control

In addition to amounts otherwise available for program integrity and program management, *$813,000,000***[**$786,000,000**]**, to remain available through September 30, *2022***[**2021**]**, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which *$628,356,426***[**$610,000,000**]** shall be for the Centers for Medicare & Medicaid Services program integrity activities, of which *$101,643,574***[**$93,000,000**]** shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, and of which $83,000,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: *Provided*, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year *2021***[**2020**]** shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation: *Provided further*, That of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and *$496,000,000***[**$475,000,000**]** is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act: Provided further, That **[**the Secretary shall provide not less than $18,000,000 for the Senior Medicare Patrol program to combat health care fraud and abuse from the funds provided to this account**]** amounts made available under this heading and amounts made available for fiscal year 2021 in section 1817(k)(3)(A) of the Social Security Act shall also be available for the Senior Medicare Patrol Program to combat health care fraud and abuse.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, *$813,000,000* **[**$786,000,000**]**, to remain available through September 30, *2022* **[**2021**]**, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act,	Authorizes appropriation to be available for obligation over two fiscal years.
of which *$628,356,426* **[**$610,000,000**]** shall be for the Centers for Medicare & Medicaid Services program integrity activities,	Provides funding for Centers for Medicare & Medicaid Services for program integrity activities.
of which *$101,643,574* **[**$93,000,000**]** shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act,	Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute.
and of which $83,000,000 shall be for the Department of Justice to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act:	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.
Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year *2021* **[**2020**]** shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation:	Specifies reporting requirement.
Provided further, That of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, and *$496,000,000* **[**$475,000,000**]** is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act:	Specifies the $311 million base amount, necessary for the incremental cap adjustment funds to be appropriated, consistent with the Budget Control Act of 2011. Additionally, specifies that once the $311 million base amount is met, that $496 million is available for appropriation as additional budget authority in FY 2021. The request includes an additional $6 million, which is an inflation adjustment applied to the $311 million base amount.
Provided further, That **[**the Secretary shall provide not less than $18,000,000 for the Senior Medicare Patrol program to combat health care	Provides funding for the Administration for Community Living to conduct the Senior Medicare Patrol program to combat health

fraud and abuse from the funds provided to this account**]** amounts made available under this heading and amounts made available for fiscal year 2021 in section 1817(k)(3)(A) of the Social Security Act shall also be available for the Senior Medicare Patrol Program to combat health care fraud and abuse.

care fraud and abuse and flexibility to fund through either discretionary or mandatory HCFAC funds.

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Health Care Fraud and Abuse Control

(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 (+/-) FY 2020
Discretionary				
CMS Program Integrity	$599,389	$610,000	$628,356	$18,356
OIG	$87,230	$93,000	$101,644	$8,644
DOJ	$78,381	$83,000	$83,000	$0
Subtotal, Discretionary	**$765,000**	**$786,000**	**$813,000**	**$27,000**
Mandatory				
CMS Program Integrity	$897,715	$914,626	$948,891	$34,265
FBI	$138,344	$141,423	$153,597	$12,174
OIG	$195,755	$200,082	$215,574	$15,492
DOJ Wedge	$61,120	$62,471	$67,308	$4,837
HHS Wedge	$37,440	$38,268	$41,231	$2,963
Subtotal, Mandatory	**$1,330,374**	**$1,356,870**	**$1,426,601**	**$69,731**
Total Funding	**$2,095,374**	**$2,142,870**	**$2,239,601**	**$96,731**

Authorizing Legislation – Social Security Act, Title XVIII, Section 1817(k)

FY 2020 Authorization – Public Law 104-191 and Public Law 116-94

Allocation Method – Other

OVERVIEW

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse.

A Collaborative Effort

Fighting health care fraud is a top priority for the Administration. In particular, CMS has made it a priority to strengthen program integrity while increasing the program integrity return on investment (ROI). The HCFAC account is structured to ensure resources provided to HHS/Office of Inspector General (OIG), Department of Justice (DOJ), and CMS allow for these entities to coordinate oversight and law enforcement efforts to target bad actors efficiently and effectively.

CMS works with law enforcement partners that take a lead role in investigating and prosecuting alleged fraud. CMS has enhanced this relationship through participating in the Medicare Fraud Strike Force teams, which investigate and track down individuals and organizations that are defrauding Medicare and other government health care programs. There are 15 Strike Forces located throughout the country.

In October 2018, the Attorney General announced the launch of the Appalachian Regional Prescription Opioid (ARPO) Strike Force. The ARPO Strike Force operates in 10 federal districts. Its goal is to investigate and charge medical professionals with the illegal prescription of opioids. As of September 2019, the ARPO Strike Force has charged more than 70 defendants who are collectively responsible for distributing more than 400 million pills.

Since their inception in March 2007, Strike Force operations have charged more than 4,200 defendants who have collectively billed the Medicare program for nearly $19 billion. CMS, working in conjunction with HHS/OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

Through collaborations such as the Medicare Strike Force teams, all three partners target areas with high incidence of fraud in order to carry out the synchronized efforts to reduce fraud and recover taxpayer dollars. Together activities like CMS' enhanced provider screening and fraud prevention projects; HHS/OIG's investigative, audit, evaluation, and data analytic work; and DOJ's investigative and prosecutorial actions and tougher sentencing guidelines, root out existing fraud and abuse while acting as a deterrent for potential future bad actors. This collaboration continues to demonstrate positive results, yielding a $4 to $1 ROI for law enforcement and detection efforts over a three-year period (2016-2018).

CMS also relies on important non-Federal partnerships to share data to address fraud and abuse. The Healthcare Fraud Prevention Partnership (HFPP) is one of our most critical programs. This is a voluntary, public-private partnership between Federal government, State and local agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations that come together to collaboratively identify and reduce fraud, waste, and abuse across the healthcare sector. We use this partnership for stakeholder engagement and to share information and leads across partners. The leads are used to conduct various studies and the results help CMS identify potential issues that may not have otherwise been caught. In FY 2019, the HFPP reached a total membership level of 142 partner organizations, comprised of 12 federal agencies, 13 associations, 70 private payers, and 47 state and local partners.

Funding History

Since its inception, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides both mandatory and discretionary funding.

In FY 2011, the Budget Control Act of 2011 (BCA) created a discretionary allocation cap adjustment for HCFAC funding for 10 years, from FY 2012 through FY 2021. Continuation of these funding streams will ensure HHS and the DOJ have the resources needed to conduct necessary program integrity activities and make certain that the right people, receive the right payment, for the right reason, at the right time. Since its inception in 1997, HCFAC has grown steadily and has returned over $32.4 billion to the Medicare Trust funds

to date and projects to save billions more over the next ten years by curtailing improper payments.

The appropriation of the HCFAC cap adjustment provided in the Further Consolidated Appropriations Act of 2020 allows HHS and DOJ to enhance existing, successful health care fraud prevention and law enforcement efforts by investing more in proven anti-fraud and abuse strategies. These efforts will continue into FY 2021 to strengthen the integrity and sustainability of the Medicare and Medicaid programs by investing in activities to prevent fraud, waste, and abuse and promote high quality and efficient health care.

Program Description and Accomplishments

Medicare Integrity Program (MIP)

CMS conducts traditional MIP activities such as Medical Review (MR), Benefits Integrity, Medicare Secondary Payer (MSP), Audits, and Provider Education, as well as using innovative approaches to prevent fraud, such as predictive analytics in claims processing. These new approaches require the use of federal employees, contractors, law enforcement, and auditors to identify, investigate, and prosecute individuals committing fraud, waste, and abuse.

CMS defines program integrity very simply: “pay it right.” CMS is developing a strategy to modernize its program integrity approach in Medicare using the following five pillars:

- Stop Bad Actors – CMS will work with law enforcement agencies to identify and take action on those who defraud the Medicare program.

- Prevent Fraud – CMS will continue to focus on moving away from a “pay and chase” model by preventing fraud, waste, and abuse on the front end.

- Mitigate Emerging Programmatic Risks – CMS will monitor new and emerging areas of risk.

- Reduce Provider Burden – CMS will ensure that its program integrity efforts do not create unnecessary time and cost burden on providers.

- Leverage New Technology – CMS plans to leverage healthcare sector innovation to modernize and automate its program integrity tools.

Specific steps CMS is taking with the current legislative authorities and financial resources available include: more stringent scrutiny of applicants seeking to bill the Medicare program; increased collaboration with law enforcement in the application of payment suspensions; enhanced oversight of Medicare Advantage (MA) and Part D Prescription Drug Plans (PDPs); and testing new methods to detect and deter potential fraudulent behaviors before and after providers and suppliers are enrolled in the Medicare program.

In FY 2021, the major initiatives CMS will fund under MIP include Provider Audit, MSP, MR, Benefits Integrity, Medicare-Medicaid Data Matching, Provider Education and Outreach, and Error Rate Measurement. These activities are funded through both mandatory MIP and discretionary HCFAC funding and will be discussed in more detail throughout the chapter.

Medicaid Integrity Program

While states have primary responsibility for combating Medicaid fraud, waste, and abuse, oversight of the Medicaid program requires a partnership, and CMS plays a significant role in supporting state efforts and increasing state oversight, accountability, and transparency. CMS uses the resources associated with Section 1936 of the Social Security Act (the Act) (described in greater detail in the State Grants and Demonstrations chapter) along with discretionary HCFAC funding in a unified, coordinated effort to address fraud, waste, and abuse in Medicaid.

There has been a rapid increase in Federal Medicaid spending driven by several factors, including Medicaid expansion, from $265 billion in FY 2013 to an estimated $448 billion in FY 2021. With this historic growth comes an equally growing and urgent responsibility to ensure sound stewardship and oversight of our program resources. As part of CMS' plan to reform Medicaid using the three pillars of flexibility, accountability, and integrity, CMS announced a new Medicaid Program Integrity strategy in June 2018 to ensure we are keeping the Medicaid program sustainable for the future.

As part of this new strategy, CMS is enabling states to improve their program integrity by offering increased data sharing and robust analytic tools. The initiatives include stronger audit and oversight functions, increased beneficiary eligibility oversight, and enhanced enforcement of state compliance with federal rules. Several highlights are listed below:

- Working to conduct independent financial audits of state claiming of federal matching dollars, as identified by the GAO and HHS/OIG.
- Auditing states' beneficiary eligibility determinations in states previously reviewed by HHS/OIG or state auditors, which includes an assessment of the impact of Medicaid expansion.
- Working closely with states to ensure that CMS and oversight bodies have access to the best, most complete and accurate Medicaid data. All 50 states, the District of Columbia, and Puerto Rico are now submitting data on their programs to the Transformed Medicaid Statistical Information System (T-MSIS), and CMS is working with states to ensure that data submissions meet the rigorous quality standards needed to support auditors and other program integrity partners.
- Working with states to enhance data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs. For example, CMS makes the Social Security Administration's Death Master File available for States to support provider enrollment activities.
- Strengthening efforts to provide effective Medicaid provider education to reduce aberrant billing, including targeted education and comparative billing reports. CMS will also work with states on other provider facing tools and investments.

Private Insurance Integrity Program

Program integrity is a priority in the Health Insurance Exchanges – both in the Federally-facilitated Exchange (FFE) and the State-based Exchanges (SBEs). CMS uses this funding for a variety of activities such as assessing consumer fraud complaints, conducting investigations and data analyses using the FFE and other data sources, and verifying insurance agent/broker licensure. CMS is developing a methodology to measure and report estimated improper payments.

HCFAC Funding History

Fiscal Year	Budget Authority
FY 2017	$1,995,082,000
FY 2018	$2,043,017,000
FY 2019	$2,095,374,000
FY 2020 Enacted	$2,142,870,000
FY 2021 President's Budget	$2,239,601,000

Budget Request: $813.0 Million (discretionary)

The FY 2021 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The total FY 2021 mandatory funding level is $1,426.6 million, $69.7 million above the FY 2020 Enacted level. The FY 2021 discretionary request is $813.0 million, $27.0 million above the FY 2020 Enacted level, and in line with the incremental increase included in the BCA.

The Budget also proposes to extend the discretionary cap adjustment, currently scheduled to end after FY 2021, through FY 2025 and then increase the FY 2025 levels for inflation though FY 2030.

The FY 2021 CMS allocation of the discretionary HCFAC request is $628.4 million. CMS' discretionary request reflects activities that support the emerging needs across all health care programs under CMS' jurisdiction, including private insurance.

In FY 2021, CMS will balance program integrity activities aimed to protect beneficiaries and the Trust Funds while minimizing provider burden; integrate, analyze, and share data to inform decision making and reduce stakeholder burden; share best practices with states and allow flexibility in program integrity approaches while improving accountability in Medicaid programs. Furthermore, CMS will expand its oversight of Medicare Part C and Part D, while clarifying and simplifying program requirements through collaboration, transparency, outreach and education. This budget request covers CMS' overall program integrity strategy, and descriptions of the activities performed within each program area are included throughout this chapter.

CMS Program Integrity – HCFAC Funding by Authority
(Dollars in Thousands)

Activity	FY 2021 Discretionary Request	FY 2021 Mandatory Funding 1/	FY 2021 Total
I. Audits	$95,984	$175,482	$271,466
II. Medical Review (MR)	$51,729	$187,011	$238,740
III. Medicare Secondary Payer (MSP)	$0	$119,805	$119,805
IV. PI Investigation, Systems & Analytics	$158,592	$169,808	$328,401
V. Technical Assistance, Outreach & Education	$61,966	$33,951	$95,917
VI. Provider Enrollment & Screening	$82,344	$39,842	$122,185
VII. Error Rate Measurement	$61,000	$20,000	$81,000
VIII. Provider & Plan Oversight	$46,087	$16,192	$62,278
IX. Appeals Initiatives	$6,042	$0	$6,042
X. Enterprise Services and Support	$18,566	$11,131	$29,697
XI. Administrative Costs	$0	$113,053	$113,053
XII. Program Support	$46,046	$62,617	$108,663
Total HCFAC	$628,356	$948,891	$1,577,247

1/ Includes HCFAC funding provided by section 1817(k)(4) of the Act for the Medicare Integrity Program, including the Medicare-Medicaid Data Match Program.

I. Audits

Program Description and Accomplishments

Auditing is one of CMS' primary instruments to safeguard payments made to institutional providers, such as hospitals, skilled nursing facilities, and end-stage renal dialysis facilities. Although many of these providers have most of their claims paid through a prospective payment system, reimbursement of several items continues on an interim basis, subject to final payment after a cost reconciliation process. In addition to provider based audits, CMS reviews cost reports, programs, plans, and plan sponsors annually. The following audit related activities within the budget request are a vital part of CMS' program integrity mission and serve as one of the most effective tools to combating fraud, waste, and abuse.

Budget Request: $96.0 million

The FY 2021 budget request for audits is $96.0 million.

- *Provider Cost Report Audit - Ongoing Operations (MACs):* Part A providers are required to submit an annual Medicare cost report which, after the settlement process, forms the basis for reconciliation and final payment to the provider. This process determines if provider payments were proper and in accordance with CMS regulations and instructions. During FY 2019, the MACs received and accepted approximately 57,985 Medicare cost reports, which included initial as well as amended cost report filings. Approximately 20,637 cost reports were desk reviewed

and tentatively settled. In addition, the MACs completed approximately 744 audits. [This activity will be funded using $136.4 million in mandatory HCFAC funds.]

- *Targeted Provider Cost Report Audits:* This activity addresses a wide range of provider focused audits. CMS is responsible for evaluating Medicare, Medicaid, and other private plan sponsors' performance in the delivery of health and drug services and ensure that beneficiaries receive appropriate services for which these sponsors have already been paid to provide. CMS' Cost Report Audit requirements are revised and improved as deemed necessary to prevent improper payments and increase the return on investment. [This activity will be funded using $31.0 million in mandatory HCFAC funds.]

- *Audit Systems: $19.3 million.* This request provides IT operational support for multiple program integrity work activities across multiple workloads including the Health Plan Management System (HPMS), Healthcare Cost Report Information System (HCRIS), PS&R-Provider Statistical & Reimbursement Report, and CMS administrative audit tracking for documentation clearances. These systems perform oversight and audit activities required by CMS in regulations and statute. [This activity will be additionally funded using $4.9 million in mandatory HCFAC funds.]

- *Risk Adjustment Data Validation (RADV):* $*41.7 million*. CMS uses diagnostic information submitted by Medicare Advantage Organizations to risk adjust payments to plans. The more diagnostic information a plan submits, typically the higher their payments from Medicare. Each year, CMS conducts RADV audits to measure the accuracy of the plan-submitted diagnostic information. As required by statute, CMS uses the results of these audits to estimate and recover overpayments for individual Medicare Advantage (MA) plans. This request also funds the Central Data Abstraction Tool, which is the primary IT system used to support the RADV audits. CMS will continue to implement process improvements to reduce the burden and the costs of the audits. In FY 2021, CMS is requesting funding to support audits for payment years 2018 and 2019, which will represent over 450 plans, totaling more than 15,000 beneficiaries.

- *Audit Validation Contractor for Part D RAC:* Section 6411(b) of the Affordable Care Act (ACA) expanded the use of statutory 1893 Recovery Audit Contract (RAC) provisions to utilize RACs under the Medicare Integrity Program for Part C and Part D. The RAC Program mission is to reduce Medicare improper payments through the detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments. [This activity will be funded using $2.1 million in mandatory HCFAC funds.]

- *Medical Loss Ratio Audits: $2.4 million*. CMS conducts other activities to ensure private plans that make or receive risk-adjusted payments, such as Medicaid Managed Care Organizations (MCO), are accurate. To that end, CMS is evaluating compliance with the Medical Loss Ratio (MLR) requirements. This work includes conducting analyses to identify the States most at risk by looking at the source data from the private plans and the State reported data. In FY 2021, CMS is increasing oversight of Medicaid MCOs and their calculations for MLR. CMS will be establishing a MLR audit process for Medicaid in accordance with existing state and NAIC regulations, subject to 42 CFR § 438.8.

- *Internal Controls Audits: $2.7 million.* The A-123 Assessment is for a Certified Public Accountant (CPA) firm to conduct a rigorous assessment of the CMS internal controls over reporting, which is required by the Office of Management and Budget (OMB) Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control, Appendix A. This assessment includes evaluating SSAE 18 internal control reviews (formerly SAS 70 audits) for Title XVIII Medicare contractors. [This activity will be additionally funded using 1.0 million in mandatory HCFAC funds.]

- *Cost Plan Audits: $3.5 million*. CMS provides fiscal oversight over MCOs. These plans report annual costs for final settlement via Cost Reports with CMS. CMS requests ongoing funding in FY 2021 to audit the Cost Report statements to ensure costs are allowable and in accordance with contract requirements and CMS regulations. The audit activities include cost report examinations performed by independent audit contractors and medical reviews performed by the medical coders.

- *Part C & D Audits: $7.5 million*. Sections 1857(d)(1) and 1860D-12(b)(3)(C) of the Act require the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the bid) of at least one-third of the MA Organizations and Prescription Drug Plans. To meet the audit requirement, CMS performs approximately 215 audits annually, as well as resolution of the audit issues noted in the audit reports. Prompt audits of the financial data will permit CMS to evaluate and refine CMS' plan oversight, thereby assuring accurate bidding and enhancing CMS' payment accuracy.

- *Targeted Programmatic Compliance Audits: $18.9 million*. CMS' FY 2021 request supports conducting audits to test whether MA Organizations, Prescription Drug Plans (Part D), Program for All-Inclusive Care for the Elderly (PACE) plans, and other private plan sponsors provided beneficiaries with the appropriate health services and medications as required under their contract with CMS.

II. Medical Review (MR)

Program Description and Accomplishments

MR activities can be conducted pre-payment or post-payment and serve to guard against inappropriate benefit payments by ensuring that the medical care provided meets all of the appropriate conditions. Complex medical review is conducted on less than one percent of claims to confirm that services and items rendered are reasonable, necessary, and comply with all Medicare coding and documentation requirements.

CMS uses MR as a way to reduce provider burden. Between October 2017 and February 2019, the MACs contacted over 20,000 providers and suppliers through the Targeted Probe and Educate (TPE) program to provide one-on-one education. As a result, approximately 80 percent of those providers and suppliers were released from further review.

CMS also conducts accuracy reviews, prior authorizations, and tasks performed by the Supplemental Medical Review Contractor (SMRC), which provides support for a variety of tasks and lowers the improper payment rate by enhancing medical review efficiencies. These tasks are national in scope and are often driven by recommendations from HHS/OIG.

Budget Request: $51.7 million

The FY 2021 budget request for Medical Review is $51.7 million.

- *Medical Review - Ongoing Operations (MACs):* CMS contracts with the MACs and the SMRC to perform analysis of FFS claims data to identify atypical billing patterns and perform claims review. MR is an example of such FFS claims data analysis. In an effort to increase proper billing, CMS continues to enhance MR efforts and has encouraged the MACs to incorporate increased provider feedback processes, such as intra-probe education and review results notifications with more detail. In FY 2018, the MACs conducted more than 240,000 TPE reviews. [This activity will be funded using $153.1 million in mandatory HCFAC funds.]

- *Supplemental Contractor: $28.6 million*. The SMRC performs and provides support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the MR functions primarily for Medicare. The SMRC supports three initiatives:

    1. Specialty Reviews for issues identified by CMS and other Federal agencies, such as HHS/OIG and the Government Accountability Office (GAO);
    2. HFPP Reviews on providers or service types that have been identified as being aberrant in HFPP studies; and
    3. Program Integrity Reviews that will focus on ensuring claims, encounter data, and Prescription Drug Event (PDE) records are paid correctly.

    CMS requests FY 2021 funding to close out HHS/OIG report recommendations and provide educational opportunities for providers that help to lower future improper payments. In FY 2021, CMS expects the SMRC to review approximately 700,000 claims. [This activity will be additionally funded using $16.6 million mandatory HCFAC funds.]

- *MR Systems: $14.2 million*. This request provides IT operational support for multiple MR activities including the National Correct Coding Initiative (NCCI) for Medicare and Medicaid, the Services Tracking Analysis and Reporting System (STARS), and the Electronic Submission of Medical Documentation (esMD). These systems aid in measuring, preventing, and correcting improper payments by ensuring proper coding of claims, controlling overpayments, and assisting in detecting, analyzing, investigating, coordinating, and documenting cases of health care fraud, waste, and abuse. [This activity will be additionally funded using $7.8 million in mandatory HCFAC funds.]

- *Prior Authorization: $5.0 million*. The FY 2021 request supports MIP activities of the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), through the prior authorization process for certain DMEPOS items. CMS established an initial Master List of certain DMEPOS items that are frequently subject to unnecessary utilization and established a prior authorization process for these items. In FY 2019, CMS added additional items that required prior authorization and plans to do so again in FY 2020 and FY 2021.

- *Accuracy Reviews: $1.9 million*. CMS uses the Medical Review Accuracy

Contractor (MRAC) to conduct MR of review determinations made by Medicare and Medicaid Medical Review Contractors (MRCs). MRCs include the Medicare Administrative Contractors (MACs), Unified Program Integrity Contractors (UPICs), the SMRC, Qualified Independent Contractors (QICs), and Quality Improvement Organization Contractors (QIOs). The MRAC helps CMS develop an accuracy score for each contractor, ensures the contractors are making the correct medical review decisions, feeds information into an Award Fee Component for the MACs, and determines where inconsistencies may be present causing improper payments. CMS requests FY 2021 funding to oversee the MR component of its contractors and assess the MAC Award Fee plans related to MR accuracy. CMS expects approximately 7,200 accuracy reviews to be completed in FY 2021.

- *Other MR Activities: $2.0 million*. The FY 2021 request provides operational support for MR activities and error rate reduction. CMS provides hospital-specific Medicare data statistics in areas identified as at risk for improper payments (unnecessary admissions, readmissions, improper billing, or coding errors). Additionally, CMS will provide a minimum of ten Comparative Billing Reports (CBRs), giving providers the opportunity to compare their billing patterns to those of their peers. [This activity will be additionally funded using $9.5 million in mandatory HCFAC funds.]

III. Medicare Secondary Payer (MSP)

Program Description and Accomplishments

Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment. The MSP provisions have protected Medicare Trust Funds by ensuring that Medicare does not pay for items and services that certain health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage. Medicare statute and regulations require that all entities that bill Medicare for items or services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those items or services.

In FY 2021, this activity will be funded using $119.8 million in mandatory HCFAC funds. This funding will support MAC operations related to MSP, the centralized MSP Coordination of Benefits & Recovery (COB&R) program, and the development and maintenance of systems and databases.

IV. PI Investigation, Systems & Analytics

Program Description and Accomplishments

This section includes the principal programs responsible for executing CMS' mission to deter, detect, and prevent fraud, waste, abuse, improper payments, and resulting administrative actions for Medicare, Medicaid, and the Exchanges. The contractors and supporting systems aid CMS in identifying cases of suspected fraud, waste, and abuse; developing cases thoroughly and in a timely manner; and taking immediate action to ensure that Medicare Trust Fund dollars are being spent appropriately. CMS has established Unified Program Integrity Contractors (UPICs) to perform program integrity functions in specified geographic areas (also called jurisdictions) covering our nationwide health programs. Benefits resulting from these programs include reduced state and provider

burden, increased contractor accountability, enhanced data and reporting capabilities, and improved program oversight. The UPICs, Medicare Integrity Drug Contractors (MEDICs), and supporting contracts/systems are the pillars for CMS' integrated program integrity strategy and key to improving contractor accountability.

Budget Request: $158.6 million

The FY 2021 budget request for PI Investigation, Systems and Analytics is $158.6 million. Funding is needed to continue sharing enrollment information with states, combat the opioid addiction epidemic, and implement new analytics through the development of models and edits for the Fraud Prevention System (FPS 2.0).

- *PI Investigative Activities - Ongoing Operations (MACs):* CMS works with each MAC to develop improper payment reduction strategies, based on vulnerabilities identified by the Comprehensive Error Rate Testing (CERT) program, the Government Accountability Office (GAO), HHS/OIG, the Medicare FFS RACs, and other sources. These funds will be used to support the MIP operational activities of the MACs in identifying and reducing payment errors. [This activity will be additionally funded using $21.9 million in mandatory HCFAC funds.]

- *Unified Program Integrity Contractors (UPICs):* The UPICs consolidate Medicare and Medicaid program integrity audit and investigation work across five geographic jurisdictions throughout the United States. Contractors conduct reviews of Medicare and Medicaid claims payments to ensure payments are appropriate and consistent with Medicare and Medicaid coverage, coding, and regulations policies. [This activity will be additionally funded using $113.7 million in mandatory HCFAC funds.]

- *Medicare Drug Integrity Contractors (MEDICs): $20.0 million*. In January 2019, CMS divided the existing MEDIC into two contracts: the previously existing National Benefit Integrity Medicare Integrity Contractor (NBI MEDIC) and the Investigations MEDIC (I-MEDIC). The NBI MEDIC has a national focus related to plan oversight pertaining to the following Part C and Part D program integrity initiatives: identification of program vulnerabilities, data analysis, health plan audits, outreach/education and law enforcement support which includes requests for information (RFI).

  In FY 2018, the NBI MEDIC:

  - Supported Part D plan sponsor oversight efforts saving an estimated $37.0 million;
  - Received approximately 7,841 actionable complaints (complaints within the scope of the NBI MEDIC);
  - Completed 893 requests for information from law enforcement;
  - Referred a total of 295 cases; and
  - Saved an estimated $2.5 million from Part C law enforcement referrals and $10.0 million from Part D law enforcement referrals.

  During FY 2018, the NBI MEDIC referred 13 providers to the Office of Inspector General/ Office of Counsel to the Inspector General (OCIG) for exclusion.

  The primary purpose of the I-MEDIC is to detect, prevent, and proactively deter fraud, waste, and abuse for high risk prescribers/pharmacies in Medicare Parts C

and D by focusing primarily on complaint intake and response, data analysis, investigative activities, referrals to law enforcement partners, and law enforcement support which includes RFIs.

During the second and third quarters of FY 2019 (January 1, 2019 – June 30, 2019), the I-MEDIC:

- Opened 622 investigations
- Referred 39 providers to CMS for revocation from Medicare;
- Completed 460 requests for information from law enforcement
- Referred 103 cases to law enforcement

- *PI Modeling & Analytics Support: $33.5 million*. CMS conducts analytics to identify fraud, waste, and abuse; utilizes rigorous statistical methodologies to assess whether program integrity vulnerabilities can be captured as models or edits in the FPS; and measures outcomes from its efforts. Aligning modeling and analytics with financial transparency helps CMS make crucial decisions regarding future direction and program funding. FY 2021 funding supports Medicare program integrity analytics and the ingestion of state Medicaid T-MSIS data. This also includes the development of models (algorithms that analyze data on paid claims) to detect patterns and trends that may represent fraud, waste, and abuse in the Medicaid and Medi-Medi programs. [This activity will be additionally funded using $3.6 million in mandatory HCFAC funds.]

- *Case Management: $22.0 million*. The Unified Case Management (UCM) system and associated operational services provide a central repository to support the UPICs, MEDICs, and other stakeholders across the Medicare and Medicaid programs. This workload includes providing the capability to track leads, audits, and investigations; capturing and managing workflow activities; reporting workload metrics; reporting status of administrative actions and referrals to law enforcement; and recording outcomes or disposition of program integrity audit and investigative actions across Medicare. The goal is to have UCM provide more timely and contextual information. This will enable CMS and its contractors to make quicker and more informed decisions, and allow for better coordination between law enforcement, program integrity contractors, and CMS. To realize this goal, the team has initiated plans to enhance medical review, as well as bringing in T-MSIS data for Medicaid case work. The UCM also supports the Major Case Coordination (MCC) initiative, which provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads.

- *One PI: $17.2 million*. CMS has built the One PI portal to provide program integrity contractors, law enforcement, and HHS/OIG with centralized access to multiple analytical tools and data sources. The portal provides access to current and historical Medicare and Medicaid data that is used to develop and refine predictive analytic models prior to integration into FPS. The FY 2021 request aids in the training and support for a multitude of contractors and law enforcement on the use of these tools and the Integrated Data Repository (IDR).

- *Fraud Prevention System (FPS):* The Small Business Jobs Act of 2010 mandates the use of predictive modeling and other analytic technologies to identify and prevent fraud, waste, and abuse in the Medicare FFS program. In 2011, CMS

developed and implemented the FPS to implement predictive analytics technologies to identify and prevent the payment of fraudulent claims in the Medicare FFS Program. The FPS system was implemented in order to apply proven and effective predictive modeling tools into the Medicare claims processing system to stop payment on high-risk claims (i.e., automated edits) and perform analysis on paid claims to generate alerts of potentially fraudulent providers for further investigation. In March 2017, CMS launched FPS 2.0 to modernize the system and user interface, and improve model development time and performance measurement. During FY 2019, the FPS generated leads that resulted in 766 new investigations and augmented information for 575 existing investigations. Funding in FY 2021 will support ongoing operations as well as implementing a machine learning initiative and including additional data sources (e.g., T-MSIS) to support edits and model development. [This activity will be funded using $30.0 million in mandatory HCFAC funds.]

- *Encounter Data Collection System (EDS): $29.9 million*. The FY 2021 request will support all development, maintenance, enhancements, requirements gathering, and analytic activities related to the collection and processing of up to 5 million encounter data records (EDRs) per day submitted by MA organizations and Medicare Medicaid Plans (MMPs) via the Encounter Data Processing System (EDPS). Funding in FY 2021 will also support a recompete of the EDPS contract. All efforts shall be performed in accordance with CMS' requirements and shall meet the objectives of increasing efficiency and effectiveness of the EDS' operations and timely implementation in support of statutory and regulatory requirements. To date, CMS has collected and processed over 4 billion MA EDRs.

- *Medicaid and CHIP Program System (MACPro): $5.6 million*. MACPro is designed to improve Federal and State program management. CMS is committed to engaging with states in a bilateral process to make the State Plan Amendment (SPA) approval process more transparent, efficient, and less burdensome. The MACPro system allows CMS and states to collaborate online to process SPAs, waivers, quality measures reports, demonstrations, advance planning documents, and other initiatives. MACPro also facilitates expedited approval of waiver and demonstration project extensions through process improvement. CMS aims to be more consistent in evaluating and incorporating state requests for specific waivers and demonstration project approaches that have already received approval in another state.

- *Transformed Medicaid Statistical Information System (T-MSIS): $16.1 million*. HHS/OIG has identified the availability of quality T-MSIS data as a priority need for program integrity activities. T-MSIS is a data ingestion application and reporting tool that encompasses the complete history, demographic information, and provider enrollment data produced in the daily operation of the Medicaid and CHIP programs. This includes data about enrollees, services, costs (including FFS), claims, encounters under managed care arrangements, and beneficiary eligibility information. This data is integral for monitoring and oversight of the Medicaid and CHIP programs, and is necessary for auditing and investigations. Enhancements to the T-MSIS system and support services for data, including data quality improvement, must continue to ensure long term national processing sustainability, improved data integrity and data sharing capabilities for state submitted data. In addition to funding from program operations, the FY 2021 HCFAC request will be used to enhance system operations by acquiring comprehensive digital service

delivery capacity to assist CMS in an effort to continue sustaining and improving T-MSIS and to support required data services for auditors and other stakeholders.

- *Exchange Fraud Complaints Process: $1.1 million*. FY 2021 funding will be used to review consumer complaints of fraud to determine whether administrative action can be taken. This activity will test the value of consumer complaints of fraud in generating action. Consumers calling the Exchange Call Center can report fraud, waste, or abuse, including identity theft. This process meets the objective of the authorizing statute to conduct investigations relating to the delivery of and payment for health care.

- *Exchange Program Integrity Review, Support and Analytics: $11.1 million*. FY 2021 funding will be used to support general investigation activities, conduct data analytics leveraging data from the FFE systems and other sources, and provide project management resources to help with large operational projects related to oversight and audit activities. These activities were previously funded from FFE user fees and Program Operations discretionary funding.

- *Other Investigative Support Systems: $2.1 million*. CMS requests FY 2021 funding to support other fraud, waste, and abuse supporting systems such as the Medicare Exclusion Database and the Compromised Numbers Checklist. [This activity will be additionally funded using $0.6 million in mandatory HCFAC funds.]

V. Technical Assistance, Outreach & Education

Program Description and Accomplishments

Technical assistance, outreach, and education are effective tools to protect the Medicare and Medicaid Trust Funds and other public resources against losses from fraud, waste, abuse, and other improper payments and to improve the integrity of the federal health care system. CMS educates Medicare providers, suppliers, and their staff about Medicare policies and procedures, including local coverage policies, significant changes to the Medicare program, and issues identified through review of provider inquiries, claim submission errors, medical review data, and CERT program data. CMS also creates and maintains key relationships, materials, and methods for representatives of the CMS, relevant Federal and State agencies, physicians and clinical staff, hospitals, health care industry, private payers, associations, clinical and analytic experts, beneficiaries, and other stakeholders affected by program integrity related activities conducted within CMS across the continuum of compliance. The activities in this section detail the various ways CMS interacts and educates our partners in delivering consumers our health care products.

Budget Request: $62.0 million

The FY 2021 budget request for Technical Assistance, Outreach and Education is $62.0 million.

- *Outreach and Education: $11.4 million*. Medicare contractors use a variety of strategies and communication channels to offer Medicare providers and suppliers a broad spectrum of information about the Medicare program, including CMS-developed materials and contractor-developed materials. FY 2021 funding is necessary for the MACs to maintain and execute an outreach and education program that will expand and enhance efforts to reduce improper payments. This

includes disseminating information, education, training, and technical assistance. CMS will support a national, multi-media outreach campaign to increase the awareness of fraud in the Medicare program and provide beneficiaries with tools to protect themselves. FY 2021 funding also supports ongoing needs for the Local Coverage Determination Data Base, the centralized MSP COB&R program, compliance training, the Learning Module System, and general PI outreach and education. [This activity will be additionally funded using $34.0 million in mandatory HCFAC funds.]

- *Healthcare Fraud Prevention Partnership: $19.6 million*. The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership between the Federal Government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations to identify and reduce fraud, waste, and abuse across the health care sector. The HFPP has implemented a Trusted Third Party to achieve its goals, which include allowing for the exchange of data and information between the public and private sectors, leveraging various analytic tools using claims and other data provided by HFPP partners, and providing a forum for public and private leaders and subject matter experts to share successful practices and effective methodologies. In FY 2019, the HFPP reached a total membership level of 142 partner organizations, comprised of 12 federal agencies, 13 associations, 70 private payers, and 47 state and local partners. This represents a growth of 21 percent in the last 12 months.

- *Senior Medicare Patrols: $18.0 million*. The mission of the Senior Medicare Patrol (SMP) program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. The Further Consolidated Appropriations Act of 2020 requires the SMP program to be funded from the HCFAC discretionary account.

- *Medicaid Enterprise System: $13.0 million*. The Medicaid Enterprise System's goal is to ensure that state Eligibility and Enrollment systems properly determine Medicaid Eligibility; state provider enrollment and screening systems properly screen and enroll providers in support of proper claiming; and, Medicaid Management Information System (MMIS) systems pay enrolled provider claims accurately and timely. Of the $13 billion requested, over $7 billion in annual CMS funding will support state development of their Medicaid Enterprise systems, including eligibility and enrollment and MMIS. The core function of this funding is to operationalize an outcomes-based CMS oversight model for these projects and provide technical assistance to states during development and implementation in accordance with regulation and sub-regulatory guidance. These tasks are necessary to reduce costs and risks, shorten development timelines, and more effectively manage these expenditures by moving states toward a more efficient and effective Medicaid program. This work seeks to enhance CMS and State Medicaid Agency's ability to implement systems that reduce fraud, waste, and abuse in state Medicaid programs.

VI. Provider Enrollment & Screening

Program Description and Accomplishments

Provider enrollment is the gateway to the Medicare and Medicaid programs and is the key to preventing ineligible providers, or if applicable, suppliers from entering either program.

CMS is committed to strengthening program integrity through investing in enrollment eligibility activities and screening. Medicare and Medicaid providers and suppliers are required to undergo screening, including enhanced screening for certain high-risk providers and suppliers, and through the activities in this section may be deemed ineligible to participate in CMS' health care programs or their enrollment revoked and consequently, ineligible for continued participation. Through provider screening and enrollment, CMS continues to prevent and reduce fraud, waste, and abuse in the Medicare and Medicaid programs and ensure that only eligible providers are caring for beneficiaries and receiving payment and therefore, protecting CMS' Trust Funds.

Budget Request: $82.3 million

The FY 2021 budget request for Provider Enrollment and Screenings is $82.3 million.

- *Provider Enrollment, Chain, and Ownership System (PECOS): $37.5 million*. PECOS is the system of record for all Medicare provider/supplier enrollment data, which includes Part A, Part B, and DME. PECOS stores all information furnished by providers/suppliers; tracks all enrollment processing by MACs; and provides feeds to FFS claims payment systems that are mission critical to processing all claims. State Medicaid programs also rely on data-sharing efforts to support requirements for screening providers. CMS is implementing PECOS 2.0, which is a ground-up redesign of the current system, and is focused on transitioning the system from a single purpose product to an enterprise resource that is a platform for all enrollments across Medicare, Medicaid, and emerging provider programs. PECOS 2.0 will be a centralized system that can support the collection, screening, and processing of multiple types (i.e., Medicare and Medicaid) of enrollments, as well as the operational oversight and program management functions associated with enrollment. [This activity will be additionally funded using $20.8 million in mandatory HCFAC funds.]

- *Advanced Provider Screening (APS): $39.6 million*. The APS is an interactive screening, monitoring, and alerting tool which serves as the central record of aggregated internal and external information on individuals and organizations. APS supports CMS' mission to identify ineligible providers and house a centralized provider repository of criminal activity, licensure status and identity information. In FY 2019, APS resulted in more than 2 million screenings. These screenings generated more than 29,000 potential licensure alerts, and more than 560 criminal alerts for potentially fraudulent providers for further review by CMS. Such review resulted in approximately 119 criminal revocations and over 250 licensure revocations. In addition to ongoing operations, there is an increase in funding for FY 2021 due to a recompete as well as transition costs.

- *National Supplier Clearinghouse (NSC):* The NSC activity is a contractual arrangement for the NSC's receipt, review, and processing of applications from organizations and individuals seeking to become suppliers of durable medical equipment, prosthetics and orthotics (DMEPOS) in the Medicare program. This process includes conducting verification and validation of information, enrollment system validation, and implementing safeguards to ensure only legitimate suppliers enter and/or remain in the Medicare program. The FY 2021 request supports a contract to perform screening and enrollment responsibilities and all provider enrollment functions nationwide. The contractor will process enrollment applications from providers/suppliers who are enrolling in Medicare Parts A, B, C, DME, and/or

Medicaid and any other future Medicare and/or Medicaid benefit types. [This activity will be funded using $19.0 million in mandatory HCFAC funds.]

- *Medicaid Enrollment & Payment Suspension: $1.0 million*. CMS requests FY 2021 funding for the ongoing development, maintenance, and support for the Medicaid Data Exchange (DEX) system. The primary function of DEX is share provider termination and revocation data among CMS and the separate Medicaid programs. CMS houses, verifies, and maintains a centralized repository of these providers. All 50 states, the District of Columbia, and Puerto Rico have access to DEX. As of the third quarter of FY 2019, CMS received 2,610 termination submissions through the DEX system from states.

- *Exchange Enrollment and Screening: $4.2 million*. CMS requests FY 2021 funding for the purpose of identifying insurance agents that are selling Exchange plans without a valid state license. CMS' Exchange program integrity goal is to protect consumers from working with individuals that do not meet the standards established by the State Departments of Insurance by checking against the State data source, Exchange enrollment data, and the Exchange agent registration list. Agents that do not have an active license in any state in which they sold insurance will be terminated from the Exchange registration list through the established process. CMS will also perform license verification work in high risk regions.

VII. Error Rate Measurement

Program Description and Accomplishments

CMS is required to measure improper payments in order to comply with the Improper Payment Information Act of 2002, as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012. CMS measures Medicare, Medicaid, and Children's Health Insurance Program (CHIP) improper payments through its improper payment measurement programs, which include the Comprehensive Error Rate Testing (CERT) program, Part C and Part D Error Rate measurement programs, and the Payment Error Rate Measurement (PERM) program. CMS is required to estimate the amount of improper payments, submit those estimates to Congress, and report on actions the agency is taking to reduce improper payments. Each year for the programs described in this section, CMS is required to evaluate a statistically valid stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. CMS is also implementing an improper payment measurement program for the Federally-facilitated Exchange (FFE) in FY 2020.

Budget Request: $61.0 million

The FY 2021 budget request for Error Rate Measurement is $61.0 million.

- *Comprehensive Error Rate Testing (CERT):* CMS developed the CERT program to calculate the Medicare FFS improper payment rate. The CERT program calculates national, contractor-specific, and service-specific improper payment rates. CERT selects a stratified random sample of approximately 50,000 claims submitted to the MACs during each reporting period. This sample size allows CMS to calculate a national improper payment rate and contractor- and service-specific improper payment rates. [This activity will be funded using $20.0 million in mandatory

HCFAC funds.]

- *Payment Error Rate Measurement (PERM): $39.0 million*. CMS developed the PERM program to measure improper payments for the Medicaid program and the Children's Health Insurance Program (CHIP). The error rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP. Notably, the error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements.

- *Exchange Improper Payment Assessment: $9.0 million*. CMS is statutorily required to annually conduct risk assessments for programs administered in order to determine susceptibility to significant improper payments, and to measure and report estimated improper payments for those programs deemed susceptible. In 2016, CMS conducted risk assessments and found the Advance Premium Tax Credit (APTC) program susceptible. Due to this finding, CMS is required to measure and report estimated improper payments for the program. The measurement program for APTC, as administered by the FFE, has been developed and implementation is planned to begin in FY 2020. The FY 2021 request will support contractor operations to estimate and report improper payments in accordance with statutory requirements.

- *Part C & D Error Rate Measurement: $13.0 million*. CMS estimates and reports program-wide error estimates for Part C and Part D each year, as required by statute. To accomplish this, CMS requests supporting documentation from MA organizations and Part D sponsors to substantiate the data upon which they were paid. The systems supporting that work are critical to securely collecting sensitive health records and providing a secure location for our reviewers to conduct their validation activities. The FY 2021 request includes funding to support the National-level Risk Adjustment Data Validation (National RADV) and the Payment Error Related to Prescription Drug Validation (PEPV) contracts.

VIII. Provider & Plan Oversight

Program Description and Accomplishments

CMS promotes transparency of our programs by linking financial, programmatic, and performance data to push accountability and uphold program efficiency and effectiveness. The activities in this section are not only intended to oversee providers and plans for effectiveness but also help consumers make informed decisions about their treatment based on knowledge gained through these activities. At the State level, CMS conducts reviews to determine if state policies and practices comply with federal regulations, identify program vulnerabilities that may not rise to the level of regulatory compliance issues, identify states' program integrity best practices, and monitor state corrective action plans. This section also includes Program Integrity related oversight functions which aid in the State/Federal governance, management of Medicare, Medicaid, and the Exchanges and activities that aid with enforcement and compliance with statutes and regulatory guidance.

Budget Request: $46.1 million

The FY 2021 budget request for Provider and Plan Oversight is $46.1 million.

- *Open Payments: $1.0 million*. Open Payments is a Congressionally mandated,

national transparency program designed to provide the public with information regarding the financial relationships between the health care industry (pharmaceutical and medical device manufacturers and their distributors) and health care providers (physicians and teaching hospitals). Open Payments is intended to help consumers make informed decisions about their treatment based on knowledge of the financial relationships that physicians or teaching hospitals have with manufacturers. The Open Payments Search Tool provides public access of all reported payments or transfers of value made to physicians and teaching hospitals. The FY 2021 funding will be used to procure a new Open Payments system award as well as continue to support the infrastructure and IT system required for the health care industry and health care providers to register, submit data, and review and dispute submitted information to validate the accuracy and quality of the data prior to publication. [This activity will be additionally funded using $16.2 million in mandatory HCFAC funds.]

This request will also be used for the implementation of the "Fighting the Opioid Epidemic with Sunshine" provision that was signed into law as part of Support for Patients and Communities Act, which includes expansions to the Open Payments program. Under the new provisions, CMS will expand the Open Payments program to include five additional provider types under the definition of a "covered recipient". The added provider types are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives. The new law also enables CMS to publish National Provider Identifiers (NPIs) for all professionals and other entities displayed on the CMS Open Payments website.

Summary of Open Payments Program Year Data

	2013*	2014	2015	2016	2017	2018
Total Number of Records Published	4.61 million	12.11 Million	12.44 million	12.33 million	11.90 million	11.40 million
Total Value of Payments	$4.34 billion	$8.58 billion	$8.54 billion	$9.00 billion	$8.97 billion	$9.35 billion

*Program Year 2013 was a partial year of data collection (August 2013 – December 2013).

- *Rate Reviews: $7.2 million*. The Rate Review contract supports CMS's efforts to improve oversight of rate setting and financial reporting for Program for All-Inclusive Care for the Elderly (PACE) and ensuring proper billing and rate reimbursement in Home and Community-Based Services (HCBS) waiver and state plan programs. The majority of individuals enrolled in PACE are dual eligible (over 90%). This includes, but is not limited to, ensuring that states are in compliance with the HCBS assurances as defined in section 1915(c) of the Act, ensuring that states are in compliance with sections 12006(a) of the 21st Century Cures Act, and the detection and prevention of fraud and abuse in the delivery of personal care and other HCBS services. This will aid CMS in making informed policy decisions and monitor rate setting in these programs, resulting in enhanced program integrity.

- *Upper Payment Limit - Disproportionate Share Hospital (UPL-DSH): $2.0 million*. This activity supports CMS in exercising oversight of Medicaid expenditures. Specifically, the project supports CMS in implementing standardized reporting of DSH cost and UPL demonstrations. The FY 2021 request will support technical

assistance to states with regard to the collection and analysis of state-reported UPL/DSH data in the updated standardized formats.

- *Part C & D Payment Analysis, Validation and Reconciliation: $8.6 million*. This activity supports the monthly Medicare Part C and Part D payment controls of validating and analyzing monthly Medicare Part C and Part D payments to ensure that the proposed payment amounts are accurate prior to payment authorization. Additional funds in FY 2021 will be used for the Retroactive Processing Contractor, which is responsible for processing retroactive transactions for all Medicare Advantage Organizations, Part D Sponsors, demonstration, cost based Plans, and PACE Organizations. CMS has engaged Oak Ridge National Laboratories to conduct research on identifying drivers of improper payment in Part C.

- *Part C & D Review of Plans and Performance: $21.7 million*. This request funds several activities that provide critical infrastructure to support the monitoring and oversight strategy for the Part C and Part D programs. Review of plans and performance and subsequent consequences of possible enforcement actions drive improvements in the industry and are increasing sponsors' compliance with core program functions in the Part C and Part D programs. CMS also evaluates the impact of our guidance and regulations that could negatively impact the quality of care provided to beneficiaries, increasing waste and costs.

- *Section 1115: $0.5 million*. Section 1115(a) of the SSA provides authority to CMS and states under Medicaid to design, implement, and test new approaches to coverage, payment, and service delivery. Section 1115(a) demonstrations vary in size and scope and represent state and federal spending of over $300 billion annually. The funding supports development of standard operating procedures; testing a more cohesive team-based approach which will include new monitoring roles for CMS staff to expand our monitoring capacity and to improve uniformity across states in how 1115 demonstrations are managed and monitored; testing and implementation of a new budget neutrality tool; and testing and implementation of new program monitoring guides, including for site visits.

- *Special Reviews Team: $5.1 million*. CMS' Special Reviews Team provides technical assistance to enhance states' implementation and compliance with health and safety oversight for Medicaid home and community-based services (HCBS), including group homes. In FY 2021, CMS plans to conduct state onsite visits to assist the state and CMS to identify best practices for ensuring individuals' health and safety in community settings and determine components of the state's oversight strategy that need to be improved. During the state visits, CMS plans to identify state training needs regarding comprehensive risk and oversight systems and will collect and analyze data to assess states' compliance with health and safety requirements.

IX. Appeals Initiatives

Program Description and Accomplishments

A claimant in disagreement with a contractor's initial determination is entitled by law and regulation to specified appeals. The appeals process allows a provider and/or a beneficiary the right to request a review or reconsideration of the determination to deny a service in full or in part. CMS' Qualified Independent Contractors (QICs) are responsible for performing

second level appeals (reconsiderations) for Medicare FFS Part A and Part B claims. HCFAC funding supports QIC participation as a party, which affords the QIC additional rights to successfully defend a claim denial (i.e., the ability to call witness, provide testimony and evidence, etc.). In this process, Hearing Officers and Administrative Law Judges (ALJs) look to the evidence of record and must base their decision upon a preponderance of the evidence. Based on experience, CMS anticipates that by invoking party status in hearings, the QICs may reduce the ALJ reversal rate and lower Medicare Trust Fund expenditures. This section also includes funding for activities supporting Medicare Part C and Part D.

Budget Request: $6.0 million

The FY 2021 budget request for Appeals Initiatives is $6.0 million. This funding supports ongoing operations for QIC Participations, system enhancements to CMS' Cases Hearings and Appeals Modernization Project activity, and operational payment and administrative support to assist with processing Part C and Part D overpayment recoveries and appeals.

X. Enterprise Services and Support

Program Description and Accomplishments

This category provides funding for services which support multiple CMS program areas including program integrity efforts or span across CMS's program integrity efforts. Examples of enterprise-wide investments are those associated with dual-eligible, Medicare-Medicaid beneficiaries, as well as program integrity activities that integrate data from across CMS to identify bad actors. Other investments focus on providing CMS-wide support and solutions to ensure operating and security standards are applied across CMS. These activities achieve economies of scale and allow for business owners to reuse existing processes to reduce cost.

Budget Request: $18.6 million

The FY 2021 budget request for Enterprise Services is $18.6 million. This funding supports HHS' Office of General Counsel in its litigation and enforcement activities that assist in the recovery of program funds as well as shared IT services and other investments to support CMS' program integrity activities. [This activity will be additionally funded using $11.1 million in mandatory HCFAC funds.]

XI. Administrative Costs

Program Description and Accomplishments

HCFAC administrative costs cover employee compensation, rent, utilities, information technology, contracts, supplies, equipment, training, and travel.

This activity will be funded using $113.1 million in mandatory HCFAC funds. In FY 2021, this funding will support 446 FTEs, including travel, training, supplies, and direct and indirect costs.

XII. Program Support

Program Description and Accomplishments

CMS uses a multifaceted approach to target all causes of fraud, waste, and abuse that result in improper payments, with a shifting emphasis towards prevention oriented activities. CMS has implemented powerful anti-fraud tools and large scale, innovative improvements to the Medicare program integrity strategy to prevent fraud before it happens. CMS continues to improve its support of and coordination with law enforcement by working closely with HHS/OIG, DOJ, and the Federal Bureau of Investigation (FBI) to focus on prevention, early detection, and data sharing, moving beyond the paradigm of pay-and-chase, while continuing an aggressive and robust program of criminal investigation and prosecution.

Budget Request: $46.0 million

The FY 2021 budget request for Program Support is $46.0 million. This funding supports risk management, process improvement, operations for the Command Center, and a number of systems investments that will aid law enforcement (e.g., One PI) as well as broader program integrity efforts for CMS.

Included in this request is $4.8 million for implementing the Medicaid PI Strategy released in June 2018. The strategy seeks to improve transparency and accountability for the Medicaid program, enable increased data sharing and more robust analytic tools, and provide further education, technical assistance and collaboration. The FY 2021 request includes initiatives such as increased oversight of beneficiary eligibility determinations and stronger audits of state claims for federal matching funds, managed care plans' medical loss ratios, and rate setting. This funding will also support efforts to increase state compliance with Medicaid provider screening, enrollment, revalidation, and NPI requirements. [The Program Support activity will be additionally funded using $62.6 million in mandatory HCFAC funding.]

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is the primary investigative agency involved in the fight against health care fraud that has jurisdiction over both the Federal and private insurance programs. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as HHS/OIG, the Food and Drug Administration (FDA), the Drug Enforcement Agency (DEA), the Defense Criminal Investigative Service (DCIS), the Office of Personnel Management Office of Inspector General (OPM/OIG), the Department of Veterans Affairs Office of the Inspector General (VA/OIG), the Internal Revenue Service - Criminal Investigation Division (IRS-CID), State Medicaid Fraud Control Units, and other state and local agencies. On the private side, the FBI is actively involved in the Healthcare Fraud Prevention Partnership, an effort to exchange facts and information between the public and private sectors in order to reduce the prevalence of health care fraud. These efforts will enable members to share successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud. In addition, the FBI maintains significant liaison with private insurance

national groups, such as the National Health Care Anti-Fraud Association, the National Insurance Crime Bureau, private insurance investigative units, and other professional associations.

FBI Budget: $153.6 Million

The FY 2021 FBI budget includes mandatory funding in the amount of $153.6 million, an increase of $12.2 million above the FY 2020 Enacted level. The mandatory increase reflects an estimated inflationary adjustment based on Consumer Price Index-Urban (CPI-U) Annual Averages and Percent Change.

HHS OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

HHS/OIG uses HCFAC funding to conduct oversight of the Medicare and Medicaid programs. This includes holding individuals and corporations that engage in healthcare-related offenses accountable through criminal and civil actions, while providing recommendations for improving the health care system to HHS policymakers, program officials, and Congress. As described in the FY 2018 HCFAC Report to Congress, in FY 2018, HHS/OIG's Medicare and Medicaid oversight efforts in resulted in 679 criminal actions and 795 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements and administrative recoveries related to provider self-disclosure matters. In addition, HHS/OIG excluded a total of 2,712 individuals and entities from participation in Federal health care programs. For FY 2018, potential savings from legislative and administrative actions that were supported by HHS/OIG recommendations were estimated by third parties, such as the Congressional Budget Office or actuaries within HHS, to be $25.6 billion.

HHS/OIG Budget Request: $317.2 Million

The FY 2021 HHS/OIG total budget is $317.2 million. The FY 2021 discretionary request is $101.6 million, which represents an increase of $8.6 million above the FY 2020 Enacted level.

In FY 2021, OIG requests $4.5 million to address opioids, other prescription drug diversion and abuse, and serious mental illness across Medicare and Medicaid programs. These additional resources will be devoted to targeting illegal prescription and distribution of opioids to Medicare and Medicaid beneficiaries. Additional resources will also be used to enhance oversight of critical programs furnishing treatment for substance use disorders and serious mental illness.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

The DOJ's litigating components (United States Attorneys, Civil Division, Criminal Division, and Civil Rights Division) are allocated HCFAC program funds to support civil and criminal health care fraud and abuse investigation and litigation. These offices

dedicate substantial resources to combating health care fraud and abuse. HCFAC funding supplements those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators, as well as funds for data analysis and litigation of resource-intensive health care fraud cases. DOJ also provides additional funding to the FBI for Strike Force investigations.

DOJ Budget Request: $150.3 Million

The FY 2021 DOJ total budget is $150.3 million. The DOJ discretionary request for FY 2021 is $83.0 million, which is the same level of funding as the FY 2020 Enacted level.

HHS WEDGE FUNDING

Program Description and Accomplishments

HHS uses resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS. For FY 2019, negotiated amounts were $37.4 million for distribution among HHS components and $61.1 million for DOJ. The HHS portion of the wedge awards funded the following activities during FY 2019:

Office of the General Counsel (OGC): OGC primarily uses HCFAC funds on activities focused on litigation aimed at the recovery of program funds and review of CMS programs to strengthen them against potential fraud, waste, and abuse. OGC's HCFAC activities in FY 2018 helped the Government establish over $2.2 billion in judgments, settlements, or other types of recoveries, savings, or receivables.

Food and Drug Administration (FDA) Pharmaceutical Fraud Program (PFP): The PFP is designed to detect, prosecute, and prevent pharmaceutical, biologic, and medical device fraud. The PFP has identified multiple alleged medical product fraud schemes through various avenues. Since the inception of the PFP, OCI has opened a total of 239 criminal HCFAC investigations. In FY 2018, FDA's ninth fiscal year of HCFAC Program activity, OCI, through its PFP, opened 38 criminal investigations, including investigations involving drug compounders, clinical trials, and foreign and domestic medical-product manufacturers. The investigations consist of allegations involving,

HHS Office of Inspector General (OIG): Wedge funds have allowed HHS/OIG to fund new pilot programs and information technology investments that improve HHS/OIG's ability to conduct oversight of the Medicare and Medicaid programs. These new projects include: purchase of new covert technologies to assist investigations; implementing new systems to automate corrspondence on exclusions and claims extraction; and a anti-fraud and abuse training program American Indians and Alaska Natives.

HHS Wedge Budget: $41.2 Million

The FY 2021 HHS Wedge request includes mandatory funding of $41.2 million, which is an increase of $3.0 million above the FY 2020 Enacted level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General. Funding allocations are determined after HHS and DOJ complete negotiations.

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Children's Health Insurance Program

Current Law
(Dollars in Thousands)

	FY 2019 Enacted	FY 2020 Estimate	FY 2021 Estimate	FY 2021 +/- FY2020
State Allotments (Healthy Kids Act P.L. 115-120)	$22,600,000	$23,700,000	$24,800,000	$1,100,000
CHIP Performance Bonus Payments (P.L. 111-3, P.L. 113-235)	$0	$4,037,227	$11,006,361	$6,969,134
Child Health Quality Improvement (P.L. 111-3,114-10, 115-120)	$0	$0	$0	$0
Redistribution Payments	$0	$0	$0	$0
Performance Bonus Payments Rescission (P.L. 115-141)	$0	$0	$0	$0
Rescission of Unobligated Balance (P.L. 116-94)/1	($2,061,000)	($3,169,819)	$0	$3,169,819
Total Budgetary Resources /2	**$20,539,000**	**$24,567,408**	**$35,806,361**	**$11,238,953**
CHIP State Allotment Outlays	$17,651,839	$17,632,000	$15,745,000	($1,887,000)
Performance Bonus Payments Outlays/3	($49,451)	$0	$0	$0
Child Health Quality Improvement Outlays	$5,844	$22,000	$33,000	$11,000
Redistribution Payments	$80,777	$0	$0	$0
Total Outlays	**$17,689,009**	**$17,654,000**	**$15,778,000**	**($1,876,000)**

1/ The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, (P.L. 115-245) rescinded $2.1 billion in unobligated FY 2019 allotments and the Department of Labor, Health and Human Services, and Education, and related Agencies Appropriations Act, 2020 (P.L. 116-94) rescinded $3.2 billion in unobligated FY 2020 allotments.
2/ Funding levels reflect new appropriations and carry-forward balances from prior years net of enacted rescissions. These funding levels are subject to change due to adjustments throughout the year.
3/ Reflects recoveries related to OIG determinations regarding improper CHIPRA bonus payments (see https://oig.hhs.gov/oas/reports/region4/41708061.pdf).

Child Enrollment
Contingency Fund
Current Law
(Dollars in Thousands)

	FY 2019 Enacted	FY 2020 Estimate	FY 2021 Estimate	FY 2021 +/- FY 2020
Child Enrollment Contingency Fund, Budget Authority /1	**$9,990,067**	**$14,871,724**	**$15,966,361**	**$1,094,637**
Temporarily Unavailable (P.L. 115-31) /2	($5,608,460)	($6,093,181)	$0	**$6,093,181**
Transfer to Performance Bonus Fund	$0	($4,037,227)	($11,006,361)	**($6,969,134)**
Payments to Shortfall States	$0	$0	$0	**$0**
Interest Estimate	$253,602	$173,180	$168,000	**($5,180)**
Total Budgetary Resources, end of year/3	**$4,635,209**	**$4,914,496**	**$5,128,000**	**$213,504**
Total Outlays	**$2,999**	**$310,000**	**$0**	**$0**

1/ Reflects both carryover resources and deposits into the Fund.
2/ The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019 (P.L. 115-245) makes $5.6 billion temporarily unavailable for obligation in FY 2019 and the Department of Labor, Health and Human Services, and Education, and related Agencies Appropriations Act, 2020 (P.L. 116-94) made $6.1 billion not available for obligation in this fiscal year.
3/ Funding levels reflect new appropriations and carry-forward balances from prior years net of enacted rescissions.

Authorizing Legislation –
The Balanced Budget Act of 1997 (BBA) (P.L. 105-33),
The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113),
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173),
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3),
The Patient Protection and Affordable Care Act (P.L. 111-148),
The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10),
The Continuing Appropriations Act, 2018 (P.L. 115-96),
The Extension of Continuing Appropriations Act, 2018 or The HEALTHY KIDS Act (P.L. 115-120),
Advancing Chronic Care, Extenders, and Social Security (ACCESS) Act (P.L. 115-123),
The Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 (P.L. 115-245).
The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2020 (P.L. 116-94).

Allocation Method – Formula grants

Program Description and Accomplishments

The Balanced Budget Act of 1997 authorized the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIP is a federal-state matching, capped grant program providing health insurance to targeted low-income children in families with incomes above Medicaid eligibility levels. This program has improved access to health care and the quality of life for millions of vulnerable children under 19 years of age. Under title XXI, states have the option to expand Medicaid (Title XIX) coverage, create separate CHIP programs, or have a combination of the two.

Since September 1999, all states, territories, commonwealths, and the District of Columbia have had approved CHIP plans. CMS continues to review states' CHIP plan amendments as they respond to the challenges of operating this program and take advantage of program flexibilities to make innovative changes.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) reauthorized CHIP from April 2009 through September 30, 2013 and increased funding by $68.9 billion through FY 2013 to maintain state programs and to cover more uninsured children. The Patient Protection and Affordable Care Act (P.L 111-148) extended funding for CHIP through FY 2015, providing an additional $40.2 billion in budget authority over the baseline. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) provided an additional $39.7 billion in budget authority for FYs 2016 and 2017. On January 22, 2018, the HEALTHY KIDS Act (P.L. 115-120) appropriated funding to CHIP for six years from FY 2018 through FY 2023. On February 9, 2018, the Bipartisan Budget Act (BBA) (P.L. 115-123) further extended CHIP funding through FY 2027.

CHIPRA also created several new programmatic features of the CHIP program. A few of the major provisions include:

CHIP Performance Bonus Payments – Created as an incentive for states to enact policies promoting the enrollment and retention of eligible children, states received bonus payments for the enrollment increase on a per child basis equal to a portion of the state's annual per capita Medicaid expenditure on children. In order to receive a performance bonus payment, states had to implement five of eight enrollment and retention provisions throughout the year and exceed a threshold enrollment level defined in statute. Performance bonus payments were initially funded with a $3.2 billion appropriation, and transfers of any unobligated national allotments and excess funds exceeding the aggregate cap from the Child Enrollment Contingency Fund. The authority for Performance Bonus payments expired at the end of FY 2013.

Child Enrollment Contingency Fund – This fund is used to provide supplemental funding to states that exceed their allotment due to higher-than-expected child enrollment in CHIP. A state may qualify for a contingency fund payment if it projects a funding shortfall for the fiscal year and if its average monthly child enrollment exceeds the targeted average number of enrollees for the fiscal year. MACRA (P.L. 114-10) extended the Child Enrollment Contingency Fund authorization through FY 2017. The HEALTHY KIDS Act (P.L. 115-120) extended the Contingency Fund through FY 2023 and the BBA authorized the Contingency Fund through FY 2027.

The Contingency Fund receives an appropriation equal to 20 percent of the Section 2104(a) CHIP national allotment appropriation under the Social Security Act. Any amounts in excess of the aggregate cap are transferred to the CHIP Performance Bonus Fund. In addition, the Contingency Fund is invested in interest bearing securities of the United States; income derived from these investments constitutes a part of the fund. To date, four states (Iowa, Michigan, Tennessee, and Oregon) have met statutory criteria and qualified for payments from the Contingency Fund. Under current law, states are not required to spend Contingency Fund payments on activities related to children's health, and territories are not eligible to receive Contingency Fund payments.

CHIP Redistribution Fund – CHIPRA also amended 2104(f) of the Social Security Act, which permits CMS to recoup unused state allotment funding to redistribute to states facing a funding shortfall if their current allotment is insufficient to meet program demand. A shortfall state is defined as a state that will not have allotment or Contingency Fund resources to meet projected costs in the current year. If there is not sufficient redistribution funding to meet the needs of all shortfall states, each state receives a pro rata share of the total funds available. Since 2012, CMS has redistributed $1.8 billion to 30 states and territories. This includes $1.4 billion awarded to 28 states and territories when CHIP did not have a full-year appropriation at the beginning of FY 2018 that was ultimately returned to the redistribution fund upon enactment of a full-year appropriation. Approximately $2.7 billion in funding is currently available for redistribution.

Child Health Quality Improvement in Medicaid and CHIP – Section 1139A of the Social Security Act requires the Secretary to identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP. Other CHIPRA requirements include developing a standardized reporting format that encourages states to voluntarily report information regarding the quality of pediatric health care, encouraging the development and dissemination of a model electronic health record format for children enrolled in the state plan under Medicaid or CHIP, and authorizing several grants and contracts to support states in reporting measures and driving quality improvement.

A total of $225.0 million at $45.0 million per year for FYs 2009-2013 was appropriated and is available until expended. Section 210 of the Protecting Access to Medicare Act of 2014 (P.L. 113-3) ensured at least $15.0 million is transferred from Medicaid Adult Health Quality funding. The transfer occurred in FY 2015 and is available until expended. In addition, MACRA (P.L. 114-10) provided $20.0 million available for Child Health Quality activities beginning on October 1, 2015. The HEALTHY KIDS Act provided $90.0 million for child health quality activities for FYs 2018 through 2023, and the ACCESS Act provided $60 million for FYs 2024 through 2027. The ACCESS Act also makes annual state reporting on the Child Core Set measures mandatory starting in FY 2024.

Medicaid and CHIP quality funding supports the Pediatric Quality Measures Program (PQMP), the CHIPRA Electronic Health Record Program, and CHIPRA Quality Demonstration Grants. The status of Child Health Quality Improvement activities in Medicaid and CHIP are discussed below:

CHIPRA Pediatric Quality Measures Program--Current efforts in the Children's Health Insurance Program Reauthorization Act Pediatric Quality Measures Program (PQMP) include a collaboration between CMS and the Agency for Healthcare Research and Quality (AHRQ) for a next phase of pediatric measure testing under a new multi-year competitive cooperative agreement program aimed at establishing partnerships with state

Medicaid/CHIP programs to support testing, use and implementation of new or enhanced pediatric quality measures (see https://grants.nih.gov/grants/guide/rfa-files/RFA-HS-16-002.html).

Currently this funding supports six PQMP grants, initially awarded in FY 2016, who are focused on testing and implementing new pediatric quality measures previously developed by the PQMP Centers of Excellence (COE) across various Medicaid and CHIP delivery systems. The grantees are collecting data on measures and testing quality improvement strategies at multiple levels of care, assessing the feasibility and usability of the new measures within the Medicaid/CHIP patient populations at the state, health plan, and provider levels to support performance monitoring and quality improvement. In addition, CMS has funded a PQMP-Learning Collaborative to provide research, implementation, and knowledge-sharing to support the PQMP grantees. The Learning Collaborative is focused on improving understanding of best practices for dissemination and implementation of quality measures to build capacity and sustainability for performance monitoring and quality improvement efforts within the Medicaid/CHIP patient populations at the state, health plan, and provider levels.

These funds will continue to support the Medicaid and CHIP child quality measures program in FY 2021, including quality measure collection, reporting, analysis, quality improvement work with state agencies, accountability through the Medicaid and CHIP Scorecard, and managed care quality.

CHIPRA Electronic Health Record (EHR) Program -- HHS jointly released development standards including data elements and standards for EHR developers to ensure relevant elements are captured in a consistent manner. The standards can be found at https://ushik.ahrq.gov/mdr/portals/cehrf?system=cehrf. Child-specific data elements and functionality recommendations are sorted into topic areas that include prenatal and newborn screening tests, immunizations, growth data, information for children with special health care needs and child abuse reporting. The format allows for the interoperable exchange of data, is compatible with other EHR standards, and facilitates quality measurement and improvement through collection of clinical quality data. Two CHIPRA Quality Demonstration Grantees (see quality grants described below), Pennsylvania and North Carolina, completed testing the impact of the Children's EHR Format in 2014. An assessment of their experience can be found in Appendix A of the Children's EHR Format Enhancement: Final Recommendation Report (see https://healthit.ahrq.gov/sites/default/files/docs/page/children-ehr-format-enhancement-final-recommendation-report.pdf).

CMS has been assessing a number of options to test targeted items of the enhanced Format with State Medicaid and CHIP programs. In FY 2019, CMS began implementation of the next phase of the model EHR format, with support from the Office of the Chief Technology Officer, by initiating activities that will connect immunization data from state immunization information systems (IIS) with existing consumer based portals. This will enable these portals to provide consumers with access to the most complete immunization data, identify state recommended vaccination schedules, and provide immunization certificates. This phase of the EHR work is expected to be completed in FY 2021.

CHIPRA Quality Demonstration Grants:

- In 2010, CMS awarded ten grants for demonstrations in 18 states to improve health care quality and delivery systems for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Focus areas for the grants included using quality measures, applying health information technology, implementing provider-based service delivery models, investigating electronic health records, and trying other innovative approaches to improve children's health.

- CMS partnered with The Agency for Healthcare Research and Quality (AHRQ) to evaluate the demonstration. The evaluation produced several resources for future use, including Spotlights for each state's work, two implementation guides, and a report.

- Spotlights can be found at: https://www.ahrq.gov/policymakers/chipra/state-spotlights/index.html.

- The final evaluation report, with links to other resources, can be found at: http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/final-report/index.html.

To share the work of CHIPRA Quality Demonstration Grants and other quality measurement and improvement resources, CMS is in the process of creating searchable web postings as a resource for States and other stakeholders to learn from the experiences of the grantees. In addition, CMS began a knowledge transfer plan in February 2016 with an all-states webinar to leverage the knowledge gains from this demonstration and disseminate lessons learned. The work culminated in September 2017, when CMS began an affinity group with eight states that focused on Medicaid and school-based health services. Specifically, the affinity group has addressed ways that Medicaid can partner with schools to improve health outcomes, using the Child Quality Measures Core Set to evaluate progress. CMS provided and facilitated expert-moderated webinars on a broad range of topics based on the needs of participating states, one-on-one consultation with states, and peer-to-peer learning.

History of Funding for State Allotments

Fiscal Year	Budget Authority
FY 2016/1	$14,621,500,000
FY 2017/2	$19,098,000,000
FY 2018/3	$17,928,000,000
FY 2019/4	$20,539,000,000
FY 2020/5	$20,530,000,000
FY 2021	$24,800,000,000

1/ Reflects rescission of $4.7 billion in funding from section 108 of CHIPRA as amended by the ACA, Consolidated Appropriations Act, 2016 (P.L. 114-113).

2/ Reflects rescission of $1.3 billion in funding from Section 301 of MACRA (P.L. 114-254, P.L. 115- 31).

3/ Reflects rescission of $3.6 billion in funding from Section 2104(a)(21) of the Social Security Act from the FY 2018 omnibus (P.L. 115-141).

4/ Reflects rescission of $2.1 billion in funding from Section 2104(a)(22) of the Social Security Act from the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 (P.L. 115-245).

5/ Reflects rescission of $3.2 billion in funding from Section 2104(a)(23) of the Social Security Act from the Future Consolidated Appropriations Act, 2020 (P.L. 116-94).

Mandatory State/Formula Grants[1]
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program
(Dollars in Thousands)

MANDATORY STATE/FORMULA GRANTS
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program
(dollars in thousands)

STATE/TERRITORY	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate	Difference +/-
Alabama	$396,288	$434,621	$449,678	15,057
Alaska	$30,418	$32,126	$38,042	5,916
Arizona	$251,666	$266,358	$259,226	-7,131
Arkansas	$167,790	$177,209	$204,765	27,556
California	$3,038,425	$3,208,988	$3,283,458	74,469
Colorado	$298,414	$315,358	$321,772	6,414
Connecticut	$101,405	$107,097	$83,957	-23,140
Delaware	$37,871	$40,021	$38,836	-1,185
District of Columbia	$49,217	$52,802	$82,631	29,829
Florida	$793,192	$842,520	$854,727	12,207
Georgia	$444,313	$469,255	$429,237	-40,018
Hawaii	$63,149	$66,694	$51,059	-15,635
Idaho	$78,353	$83,343	$99,948	16,605
Illinois	$392,710	$414,755	$358,125	-56,630
Indiana	$261,535	$276,216	$243,120	-33,096
Iowa	$130,026	$146,382	$147,231	848
Kansas	$119,145	$125,833	$150,835	25,002
Kentucky	$218,000	$230,237	$232,613	2,375
Louisiana	$373,254	$394,207	$425,460	31,253
Maine	$37,049	$39,129	$33,334	-5,795
Maryland	$316,638	$334,413	$334,671	259
Massachusetts	$724,570	$765,244	$709,071	-56,172
Michigan	$273,742	$289,108	$295,751	6,642
Minnesota	$129,392	$137,017	$125,587	-11,429
Mississippi	$257,202	$271,641	$261,682	-9,959
Missouri	$278,965	$294,625	$291,894	-2,732
Montana	$91,428	$96,605	$108,673	12,068
Nebraska	$87,084	$92,167	$81,441	-10,726
Nevada	$78,194	$83,404	$73,884	-9,520
New Hampshire	$44,854	$47,372	$52,758	5,386
New Jersey	$519,667	$548,839	$542,976	-5,863
New Mexico	$101,350	$107,040	$101,529	-5,510
New York	$1,473,123	$1,555,817	$1,497,405	-58,413

North Carolina	$500,692	$528,799	$639,568	110,769
North Dakota	$26,680	$28,532	$27,060	-1,472
Ohio	$520,821	$550,058	$482,911	-67,147
Oklahoma	$233,625	$246,739	$243,805	-2,935
Oregon	$370,148	$511,303	$475,312	-35,991
Pennsylvania	$668,188	$705,698	$675,623	-30,075
Rhode Island	$92,975	$98,195	$83,951	-14,244
South Carolina	$184,648	$335,678	$195,538	-140,140
South Dakota	$31,233	$33,213	$29,712	-3,501
Tennessee	$234,625	$247,943	$202,244	-45,699
Texas	$1,510,172	$1,601,525	$1,397,160	-204,365
Utah	$135,050	$143,321	$113,796	-29,525
Vermont	$28,251	$29,836	$25,453	-4,384
Virginia	$378,406	$410,270	$376,176	-34,094
Washington	$236,313	$251,250	$309,804	58,554
West Virginia	$77,391	$81,736	$80,315	-1,421
Wisconsin	$272,798	$288,112	$232,075	-56,036
Wyoming	$13,382	$14,133	$11,642	-2,492
Subtotal	**17,173,827**	**18,452,783**	**17,867,521**	**-585,262**
Commonwealths and Territories				
American Samoa	$4,832	$5,103	$5,389	286
Guam	$32,227	$34,036	$35,947	1,911
Northern Mariana Islands	$11,196	$11,825	$12,489	664
Puerto Rico	$182,575	$192,824	$93,276	-99,548
Virgin Islands	$10,948	$11,562	$15,705	4,143
Subtotal	**241,777**	**255,349**	**162,805**	**-92,544**
TOTAL RESOURCES	**17,415,605**	**18,708,132**	**18,030,326**	**-677,806**

/1 Represents proposed law baseline projections of obligations.

Note: Allotments to states remain available for federal payments for two years.

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State Grants and Demonstrations
Budget Authority[1]
(Dollars in Thousands)

Budget Authority

Program	FY 2019 Enacted	FY 2020 Estimate	FY 2021 Estimate	FY 2021 +/- FY 2020
Medicaid Integrity Program	$82,179	$84,008	$91,239	$7,231
Demonstration Project to Increase Substance Use Provider Capacity	$55,000	$0	$0	$0
Money Follows the Person (MFP) Demonstration	$254,500	$176,000	$0	($176,000)
Total Appropriation	**$391,679**	**$260,008**	**$91,239**	**($168,769)**

Authorizing Legislation - Deficit Reduction Act of 2005, Public Law 109-171; Patient Protection and Affordable Care Act, Public Law 111-148 together with the Health Care and Education Reconciliation Act of 2010, Public Law 111-152; HEALTHY KIDS Act of 2018, Public Law 115-120; SUPPORT for Patients and Community Act, Public Law 115-271; Medicaid Extenders Act of 2019, Public Law 116-3; Sustaining Excellence in Medicaid Act of 2019, Public Law 116-39; Further Consolidated Appropriations Act, 2020, Public Law 116-94.

[1] This table reflects new budget authority and does not include carryover resources. This table does not include the following programs/laws: Ticket to Work, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, the Second Emergency Supplemental Appropriations Act to Meet Immediate Needs Arising From the Consequences of Hurricane Katrina, 2005, Katrina Relief - Additional Federal Payments Under Hurricane-related Multi-state Section 1115 Demonstrations, Application of Prospective Payment System for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics, Medicaid Emergency Psychiatric Demonstration, Medicaid Incentives for the Prevention of Chronic Diseases, Psychiatric Residential Treatment Facilities, Grants to Improve Outreach and Enrollment, and Funding for the Territories since the Budget Authority is $0 or the money has been rescinded.

Gross Outlays[2]
(Dollars in Thousands)

Gross Outlays

Program	FY 2019 Actual	FY 2020 Estimate	FY 2021 Estimate	FY 2021 +/- FY 2020
Ticket to Work	$103	$0	$0	$0
Katrina Relief	$1,512	$0	$0	$0
Money Follows the Person (MFP) Demonstration	$290,560	$339,791	$322,084	($17,707)
MFP Research & Evaluation	$0	$1,514	$0	($1,514)
Medicaid Integrity Program	$81,149	$66,396	$71,608	$5,212
Grants to Improve Outreach and Enrollment	$5,272	$6,527	$20,301	$13,774
Medicaid Incentives for Prevention of Chronic Diseases	$16	$150	$149	($1)
Demonstration Programs to Improve Community Mental Health Services	$1	$674	$951	$277
Demonstration Project to Increase Substance Use Provider Capacity	$0	$21,800	$13,861	($7,939)
Total Outlays for State Grants and Demonstrations	**$378,613**	**$436,852**	**$428,954**	**($7,898)**

[2] Amounts on this table include outlays from obligations made in previous fiscal years. These outlay estimates are based on PB 2021 baseline estimates.

Program Description and Accomplishments

The State Grants and Demonstrations account has historically provided federal funding for a diverse group of grant programs and other activities established under several legislative authorities. The activities have empowered states to drive innovation to improve quality and health outcomes and assist in providing state infrastructure support and services to targeted populations, including resources to combat fraud, waste and abuse, and ensuring taxpayer dollars can focus on providing high quality care to beneficiaries.

Funding History /1

Fiscal Year	Budget Authority
FY 2016	$560,102,837
FY 2017	$78,015,664
FY 2018	$199,910,665
FY 2019	$391,678,964
FY 2020	$260,008,189
FY 2021	$91,239,499

1/ Reflects new appropriations in a given fiscal year. Does not include balances from previous appropriations.

Budget Overview

The various grant and demonstration programs are appropriated federal funds through several legislative authorities. The legislation which authorizes these programs determines the amount and period of availability of funds. The following is a description of each grant and demonstration program and its associated funding.

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

Program Description and Accomplishments

Authorized in Section 6071 of the Deficit Reduction Act of 2005 (DRA), as amended by Section 2403 of Patient Protection and Affordable Care Act, the Medicaid Extenders Act of 2019 and the Medicaid Services Investment and Accountability Act of 2019, the MFP demonstration supports state efforts to empower individuals to take ownership of their health and ensure that patients have flexibility and information to make choices as they seek care by:

- Rebalancing their long-term services and supports system so that individuals have a choice of where they live and receive services;
- Transitioning individuals from institutions who want to live in the community; and
- Implementing a system that provides the person-centered services and a quality management strategy that ensures provision and improvement of both home and community-based settings.

The demonstration provides for an enhanced Federal Medical Assistance Percentage (FMAP) for 365 days of qualified home and community-based services (HCBS) for each person transitioned from an institution to the community during the demonstration period. To be eligible for the demonstration, individuals must reside in a qualified institution for at least 90 days before they transition to the community, with the exception that any days an individual resides in an institution solely for the purpose of short-term rehabilitative services for which payment is limited under Medicare are excluded. In addition, states must continue to provide community-based services after the 365 day demonstration period for as long as the individual needs community services and is Medicaid eligible.

The CMS MFP Tribal Initiative (TI), which received funding under the authority of Section 2403 of Patient Protection and Affordable Care Act offers existing MFP state grantees and tribal partners the resources to build sustainable community-based long-term services and supports (CB-LTSS) specifically for Indian Tribes. The TI may be used to advance the development of an infrastructure required to implement CB-LTSS for American Indians and Alaska Natives (AI/AN) using a single or a variety of applicable Medicaid authorities. In April 2014, CMS awarded a total of $1.5 million to five MFP grantees for the first phase of the program development. The amounts in the table on the following page are inclusive of these supplemental awards.

According to the 2016 Report, *Money Follows the Person Demonstration: Overview of State Grantee Progress*, (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/2016-cross-state-report.pdf), program transitions for the period from January 1, 2016 through December 31, 2016 numbered 11,217, which represents a 19 percent increase in cumulative transitions over the previous year for a total of 75,151. For the period January 1, 2017 through December 31, 2018, grantees self-reported having transitioned an additional 18,640 individuals for a total of 93,791.

Budget Overview

Section 6071 of the DRA authorized and appropriated a total of $1.8 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. Section 2403 of Patient Protection and Affordable Care Act amended the Deficit Reduction Act providing $450.0 million in each fiscal year from 2012-2016, totaling an additional $2.3 billion. In addition, Section 6071 of the DRA allows funding from each fiscal year's award to be used that fiscal year and for four additional fiscal years. CMS awarded multi-year grants in FY 2016 allowing the funds to be expended through FY 2020. CMS will continue to monitor each states' grant activities progress and expenditures through the entire project period. Most recently, the Medicaid Extenders Act of 2019 (P.L. 116-3) amends the DRA to make $112.0 million available for states with approved MFP demonstrations for FY 2019 and extends state MFP demonstrations through FY 2021. Of the $112.0 million, $500,000 will be available to carry out funding for quality assurance and improvement, technical assistance, and oversight. The Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16) included an additional $20.0 million and the Sustaining Excellence in Medicaid Act added 122.5 million in funding for the program. The Further Consolidated Appropriations Act, 2020 (P.L. 116-94) provided an additional $176 million in funding for the program in FY 2020.

States participating in the MFP demonstration are provided reimbursement for approved home and community-based services at an enhanced FMAP rate. The enhanced FMAP increases the regular FMAP rate for HCBS by the number of percentage points equal to

50 percent of the state share, capped at 90 percent. The American Reinvestment and Recovery Act of 2009 authorized an increased FMAP rate to preserve a significant differential between the MFP enhanced FMAP and the increased FMAP that states were receiving for most other Medicaid funded services under the Recovery Act in order for states to continue to have a financial incentive to meet the goals of the MFP program. This increase is reflected in the chart below.

Of the original DRA appropriation of $1.8 billion, a total of $2.4 million was made available in fiscal years 2007 and 2008 to carry out technical assistance for, and oversight of, states' efforts to improve quality under HCBS waivers and $1.1 million per year for evaluation and reporting to Congress. In addition, Section 2403 of Patient Protection and Affordable Care Act authorized $1.1 million from each year's appropriation in FY 2012 through FY 2016 that was used to carry out evaluation and a required report to Congress (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf).

As of December 1, 2019, CMS obligated $3.7 billion in grants to 44 grantee states and the District of Columbia (DC). Grantees have transitioned approximately 93,791 individuals as of December 31, 2018, based on individual state reporting.

State	***Cumulative Award Total***	***Initial Award Date***
Alabama	$20,110,401	September 27, 2012
Arkansas	$59,838,949	January 1, 2007
California	$197,640,171	January 1, 2007
Colorado	$21,878,138	April 1, 2011
Connecticut	$234,576,991	January 1, 2007
Delaware	$14,264,778	May 1, 2007
District of Columbia	$34,658,883	May 1, 2007
Georgia	$159,170,550	May 1, 2007
Hawaii	$7,798,138	May 1, 2007
Idaho	$21,859,299	April 1, 2011
Illinois	$45,195,803	May 1, 2007
Indiana	$92,059,136	January 1, 2007
Iowa	$77,661,590	January 1, 2007
Kansas	$65,487,431	May 1, 2007
Kentucky	$74,068,555	May 1, 2007
Louisiana	$83,884,594	May 1, 2007
Maine	$10,371,462	April 1, 2011
Maryland	$178,803,155	January 1, 2007
Massachusetts	$95,060,502	April 1, 2011
Michigan	$88,242,009	January 1, 2007
Minnesota	$76,608,425	April 1, 2011

State	*Cumulative Award Total*	*Initial Award Date*
Mississippi	$31,386,543	April 1, 2011
Missouri	$82,353,917	January 1, 2007
Montana	$9,306,595	September 27, 2012
Nebraska	$22,184,278	January 1, 2007
Nevada	$10,943,591	April 1, 2011
New Hampshire	$13,972,772	January 1, 2007
New Jersey	$120,250,213	May 1, 2007
New Mexico	$595,839	April,1 2011
New York	$184,796,857	January 1, 2007
North Carolina	$46,254,702	May 1, 2007
North Dakota	$31,340,262	May 1, 2007
Ohio	$397,621,766	January 1, 2007
Oklahoma	$52,023,929	January 1, 2007
Oregon	$22,655,153	May 1, 2007
Pennsylvania	$153,143,765	May 1, 2007
Rhode Island	$17,859,069	April 1, 2011
South Carolina	$8,237,969	April 1, 2011
South Dakota	$7,386,958	September 27, 2012
Tennessee	$67,363,025	April 1, 2011
Texas	$397,958,482	January 1, 2007
Vermont	$17,602,508	April 1, 2011
Virginia	$80,380,082	May 1, 2007
Washington	$200,049,764	January 1, 2007
West Virginia	$17,283,347	April 1, 2011
Wisconsin	$64,386,314	January 1, 2007

NOTE: The table represents funding awarded to states. Funding for planning grants, quality initiatives, and reductions associated with sequestration are not reflected. Data on the last MFP transition was excluded from this year's report since MFP was extended through the Medicaid Extenders Act of 2019.

New Mexico and Florida had no transitions through the MFP program, rescinding grant awards in January 2012 and August 2013 respectively. Oregon deactivated their program in 2011 and officially closed out the grant in September 2016.

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

On February 8, 2006, Section 6034 of the Deficit Reduction Act of 2005 (DRA) (Public Law 109-171) established the Medicaid Integrity Program in Section 1936 of the Social Security Act (the Act). With the passage of this legislation, Congress provided the Centers for Medicare & Medicaid Services (CMS) with increased resources to prevent, detect, and reduce fraud, waste, and abuse in the Medicaid program, ensuring that taxpayer dollars can focus on providing high quality care to beneficiaries.

In 2015, the Patient Access and Medicare Protection Act (Public Law 114-115) amended Section 1936 of the Act, providing CMS with greater flexibility to use a mix of contractors and federal personnel to achieve the objectives of the Medicaid Integrity Program and more quickly adapt to changing program integrity needs. Today, CMS staff and contractors funded by the Medicaid Integrity Program work closely with the Health Care Fraud and Abuse Control (HCFAC) program to address Medicaid fraud, waste, and abuse through a unified and coordinated effort. Some of the key projects included in that unified effort are described below. Other details are included in the HCFAC chapter.

The Deficit Reduction Act directed CMS to establish a Comprehensive Medicaid Integrity Plan (CMIP) every five years outlining its strategy for combating fraud, waste, and abuse in Medicaid. The first CMIP was published in July 2006, and covered FYs 2006 through 2010. CMS released the most recent CMIP in July 2014 for FYs 2014 through 2018, available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf. CMS is now working on the next CMIP and expects to finalize it in FY 2020.

Medicaid Program Integrity Strategy

In June 2018, CMS released a Medicaid Program Integrity Strategy, outlining its program integrity priorities in light of growing Medicaid expenditures and enrollment over the past several years. The Strategy also seeks to address Medicaid program integrity challenges identified by the HHS Office of Inspector General (OIG) and the Government Accountability Office (GAO). Under the Strategy, CMS is:

- Conducting audits of select states' managed care organization (MCO) financial reporting by reviewing compliance with Medical Loss Ratio to make sure claims experience matches what plans have been reporting.
- Working to conduct independent financial audits of state federal match claiming, based in part on issues identified by the GAO and OIG.
- Auditing states' beneficiary eligibility determinations in four states previously reviewed by OIG or state auditors, which includes assessments of the accuracy of eligibility determinations and state claiming for the Medicaid expansion population in those states.
- Working closely with states to ensure that CMS and oversight bodies have access to the best, most complete and accurate Medicaid data. For the first time, all 50 states, D.C., and Puerto Rico are now submitting data on their programs to the Transformed Medicaid Statistical Information System (T-MSIS).

- Sharing its extensive knowledge gained from processing and analyzing large, complex Medicare data sets to help states apply algorithms and insights to analyze Medicaid state claim data and identify potential areas to target for investigation.
- Piloting a process to screen Medicaid providers on behalf of states. Centralizing the process will improve efficiency and coordination across Medicare and Medicaid and decrease state burden.
- Working with states to enhance data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs. For example, CMS is making the Social Security Administration's Death Master File available for states to support provider enrollment activities. CMS has also created and released the CMS Data Exchange (DEX) system, a platform for more effectively and efficiently sharing State Medicaid provider terminations data.
- Releasing a Medicaid and CHIP scorecard that presents state performance measures related to their Medicaid programs, including measures of state program integrity performance. In addition to state interactions with their Unified Program Integrity Contractors (UPICS) or the Healthcare Fraud Prevention Partnership (HFPP), which have already been released, future versions of the scorecard will include other state program integrity performance measures, such as Payment Error Rate Measurement (PERM)-specific information.
- Strengthening efforts to provide effective Medicaid provider education to reduce aberrant billing, including targeted education and comparative billing reports. CMS also will work with states on other provider facing tools and investments.
- Releasing sub regulatory guidance for the Program Integrity provisions of the 2016 Medicaid Managed Care final rule. CMS will monitor state implementation of, and enforce compliance with, program integrity safeguards in the final rule, including (1) reporting overpayments and fraud, and (2) screening and enrolling Medicaid managed care providers.
- Implementing new state-specific PERM Corrective Action Plan intake and monitoring process with emphasis on reducing the improper payment rates in the Medicaid program and the Children's Health Insurance Program (CHIP), by focusing on reducing repeat findings within each state.
- Continuing to implement the Medicaid Eligibility Quality Control (MEQC) program, which uses state-directed reviews in the two off-cycle PERM years to address Medicaid beneficiary eligibility errors. MEQC focuses on areas not addressed through PERM reviews and on areas identified as error-prone through the PERM program. CMS released Phase 1 of the MEQC guidance in August 2018 and is working to release Phase 2 of the guidance in the coming months.

CMS continues to move these strategy initiatives forward, and in June, 2019, released a one-year anniversary Medicaid PI Strategy webpage found at: https://www.cms.gov/About-CMS/Components/CPI/Medicaid-PI-Strategy.html and a blog from Administrator, Seema Verma, available at: https://www.cms.gov/blog/medicaid-program-integrity-shared-and-urgent-responsibility. The Strategy is available at: https://www.medicaid.gov/state-resource-center/downloads/program-integrity-strategy-factsheet.pdf

Unified Program Integrity Contractors (UPICs)

Congress originally mandated that CMS enter into contractual agreements with eligible

entities to do the following:

- Review the actions of individuals or entities furnishing items or services to determine whether fraud, waste, or abuse has occurred, is likely to occur, or otherwise might result in expenditures not intended under Medicaid;
- Audit claims, including cost reports, consulting contracts, and risk contracts;
- Identify overpayments; and,
- Conduct education of state or local officers, employees, independent contractors, providers of services; managed care entities, beneficiaries, and other individuals.

CMS meets these obligations through a Unified Program Integrity Contractor (UPIC) strategy that consolidates Medicare and Medicaid program integrity audit and investigation work. The UPICs perform the work of the previously used Medicaid Integrity Contractors (MICs) and the Medicare Zone Program Integrity Contractors (ZPICs), including their Medicare-Medicaid Data match activities. The overarching goal of the UPICs is to integrate these program integrity functions by implementing a contracting strategy that rationalizes CMS's relationships with providers, leverages existing resources, and enhances cooperative efforts with partners, including states. CMS began awarding UPIC contracts in 2016 and all five UPICs became fully operational as of June 2018.

In FY 2019, the UPICs initiated Medicaid provider investigations and audits in 32 states. The most common collaborative investigations and audits have been conducted in the areas of hospice, credit balance and opiods non-emergency medical transportation and general hospital services. Each of these investigative areas includes both fee for service and managed care providers.

Medicaid/CHIP Financial Management Project

Previously funded under HCFAC, this project involves Financial Management (FM) staff, including accountants and financial analysts, who work to improve CMS' financial oversight of the Medicaid and CHIP programs. In FY 2018 through the continued efforts of these specialists, CMS removed an estimated $1.0 billion (with approximately $358.0 million recovered and $650.0 million resolved) of approximately $10.2 billion identified in questionable Medicaid costs.

Furthermore, an estimated $507.0 million in questionable reimbursement was actually averted due to the FM staff preventative work with states to promote proper state Medicaid financing. The FM staff activities included reviews of proposed Medicaid state plan amendments that related to reimbursement; development of financial management reviews; research regarding state Medicaid financing policy and practices; collaboration with states to resolve the Medicaid and CHIP portions of the A-133 state single audits; and reviews of sources of the non-federal share.

The FY 2019 accomplishments will be released in either the HCFAC or MIP reports to congress at a later date.

Medicaid Integrity Institute (MII)

In collaboration with the United States Department of Justice (DOJ), CMS also established the MII to provide state employees with comprehensive training courses encompassing numerous aspects of Medicaid program integrity.

The MII continues to be cited repeatedly by states, the GAO, the OIG, the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Association for Medicaid Program Integrity (NAMPI), and the National Association of Medicaid Directors (NAMD) as making a substantial contribution to state efforts to combat fraud and other improper payments. From its inception in 2008 through 2019, the MII has trained state employees from all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands through more than 9,800 enrollments in 207 courses and 19 workgroups. In FY 2020, the MII will conduct 21 courses and hold 3 workgroup meetings with 1,200 enrollments. The MII developed a distance learning program in 2012, in addition to its classroom activities, and has sponsored numerous webinars. The MII intends to further promote and expand its training capacity to even more state program integrity staff by adding even more distance learning opportunities to the calendar in the upcoming years.

The MII offers the Certified Program Integrity Professional (CPIP); a credentialing program for state Medicaid program integrity employees to certify their professional qualifications. At the conclusion of FY 2019, 426 state employees in 47 states had received the credential of Certified Program Integrity Professional. In addition, the MII supports a secure, web-based information sharing system called the Regional Information Sharing System (RISS) that all states may use to exchange documents, questions and answers, tips, and best practices about Medicaid program integrity under the auspices of the Bureau of Justice Information Assistance within the DOJ. CMS plans to enhance the educational opportunities provided through the MII by expanding course offerings and other training opportunities. CMS made significant enhancements in FY 2019:

- In February 2019, the MII held a new Public Assistance Reporting Information System (PARIS) Data Intensive course that addressed utilizing PARIS data to identify beneficiaries who may be dually enrolled in Medicaid (and/or other assistance programs) in two or more states at the same time. This included identification of best practices in using PARIS data, and also addressed the PERM, and the MEQC programs as they relate to beneficiary eligibility and enrollment.

- In March 2019, the Healthcare Fraud Prevention Partnership (HFPP) meeting was held, in conjunction with the Program Integrity Director's conference to support HFPP members sharing fraud, waste and abuse cases and schemes, as well as an opportunity to discuss best practices. Awareness was raised regarding the benefits of HFPP with hopes of additional states choosing to partner with the other HFPP members as an additional approach to combat fraud, waste and abuse.

- In March 2019, the MII, through a partnership with a workgroup of state program integrity staff, established a new course on investigative skills. This course supported newer state program integrity staff to improve and refine investigative skills at an entry level, to improve investigative planning, enhance interviewing techniques, the use of social media, safety measures in the field, and beyond.

- In July 2019 a highly-attended, new symposium for UPICs and state program integrity directors was held that brought program integrity directors and their UPIC Contractors together to address coordination and collaboration on process management, investigation/audit development and oversight, and use of T-MSIS data.

- In February 2018, CMS released a white paper entitled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services," which resulted from an MII course where program integrity professionals reached consensus recommendations to help states more effectively protect vulnerable beneficiaries, fight fraud, and reduce improper payments in personal care services. The purpose of this paper is to provide and disseminate a compendium of the program integrity vulnerabilities and mitigation strategies in personal care services developed by MII participants to inform Medicaid programs nationwide. In July 2019, as a result of this MII course and white paper, CMS released an FAQ regarding the allowability of using National Provider Identifiers (NPIs) for personal care attendants, found at: NPIs for Medicaid PCAs FAQ.

FY 2020 and 2021 will showcase additional "Trends in Medicaid" series courses. The topics will focus on the latest trends in Medicaid, including discussions on fraud, waste, and abuse, as well as, new regulatory requirements and are selected in consultation with federal and state partners. In addition, the CPIP certificate program will be revamped to support increased numbers of certified state staff, as well as an improved track to support the different staff positions held within the program integrity units, as well as updated content with new and updated regulations for relevance

State Program Integrity Reviews

Since 2007, CMS has conducted state program integrity reviews, which assess the operations of each state's Medicaid program integrity unit and report on vulnerabilities and best practices. CMS has completed 76 focused program integrity reviews on specific target areas since FY 2014 through FY 2019. These reviews have focused on a number of issues including the enhanced provider screening and enrollment provisions resulting from the Patient Protection and Affordable Care Act, the extent of states' program integrity oversight of the managed care program, the extent of selected managed care organizations' oversight of their own programs, and issues in personal care services. CMS also conducts additional reviews that encompass a broader assessment of program vulnerabilities and risk of Medicaid improper payments. Known as desk reviews, these reviews allow CMS to increase the number of states that received customized program integrity oversight.

The Medicaid program integrity review strategy includes both focused reviews (conducted onsite) and desk reviews (conducted remotely) of states. Since their inception in FY 2016, CMS has completed 268 desk reviews in at least 45 states and the District of Columbia. The desk reviews allow CMS to increase the number of states that receive program integrity oversight. On November 14, 2019, CMS awarded a new five year contract to support Program Integrity reviews. Additionally, CMS has hosted conference calls with states to discuss program integrity issues and best practices, and issued guidance on policy and regulatory issues that have been of considerable value to states. The program integrity reviews provide the opportunity for assistance from CMS.

Technical Assistance and Education to States

The Medicaid Integrity Program provides additional support to states through technical assistance from CMS staff and through contracted educational activities. CMS plans to expand general technical assistance at states' requests on topics such as managed care, PERM, MEQC, and beneficiary fraud.

CMS also assists in the education of Medicaid providers, beneficiaries, and Managed Care Organizations (MCOs) on program integrity efforts by developing materials, conducting training, providing educational resources to educate providers, beneficiaries, MCOs and stakeholders, promoting best practices and fraud and compliance awareness, and encouraging Medicaid beneficiaries to report fraud, waste, abuse, and suspected criminal activities. CMS maintains an online resource for Medicaid program integrity education (http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html). The website includes a wide array of resources on relevant fraud, waste, and abuse topics using a variety of media including print and electronic formats, toolkits, train-the-trainer guides, webinars, YouTube videos, and other strategies. State staff has access to train-the-trainer resources to conduct ongoing education for their co-workers' providers, beneficiaries, and MCOs in their states. CMS is working with state partners to understand what existing content is relevant, new content that is needed, and how CMS can improve web presence to support the states.

Additionally, CMS conducts Technical Assistance Group (TAG) calls with different states. During these TAG calls, states share resources and best practices, have the opportunity to ask questions to CMS and other states, and discuss trending issues in program integrity. The calls include the following topics:

- Program Integrity Director's Discussion of Fraud, Waste and Abuse,
- Small States,
- Data Analytics,
- Provider Enrollment,
- Beneficiary Fraud, and
- Value Based Payments.

In FY 2020 and FY 2021, CMS will continue to offer assistance to states regarding provider screening and enrollment requirements in an effort to reduce improper payments. Activities under this initiative include: visits to states to provide one-on-one technical assistance, feedback, and collect and disseminate best practices; continue to offer the CMS data compare service, which allows states to compare their provider population to the Medicare provider population in bulk to more easily rely on Medicare's screening and reduce the state's overall workload; a dedicated CMS contact to work directly with the state in addressing concerns, questions, and issues that may arise regarding provider screening and enrollment.

CMS continues to collect best and promising practices in program integrity from states and shares those practices with states on the RISS and encourages states to exchange documents, tips, and success stories with Medicaid program integrity. CMS will continue to promote the RISS website to states as a collaborative tool and repository for educational program integrity resources.

Budget Overview

The DRA appropriated funds yearly beginning in FY 2006, and beginning in FY 2011, Section 1303(b) (3) of Public Law 111-152 adjusted this funding by the percentage increase in the CPI-U annually. The FY 2019 budget authority is $85.6 million with a CPI-U adjustment of 2.4 percent, bringing the adjusted budget authority to $87.6 million. The

FY 2019 budget authority is reduced by 6.2 percent due to sequestration, bringing the final budget authority to $82.2 million. The FY 2020 budget authority is $87.6 million with an estimated CPI-U adjustment of 1.9 percent, bringing the adjusted budget authority to $89.3 million. The FY 2021 budget authority is $89.3 million with an estimated CPI-U adjustment of 2.2 percent, bringing the adjusted budget authority to $91.2 million. The CPI-U adjustments are based on the current FY 2021 President's Budget economic assumptions. Funds appropriated remain available until expended.

GRANTS TO IMPROVE OUTREACH AND ENROLLMENT
Program Description and Accomplishments

Program Overview

The grants provide outreach, education, and application assistance to enroll eligible, uninsured children in Medicaid and Children's Health Insurance Program (CHIP) and improve retention of eligible children who are currently enrolled, with a particular focus on children who are the most difficult to reach and enroll. Recognizing that traditional methods of outreach had not been effective with these children and families, the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 introduced funding to develop specialized strategies to target these children by organizations that would have access to, and credibility with families in the communities in which these eligible but uncovered children resided.

Since the Connecting Kids to Coverage Outreach and Enrollment grant funding initiatives began in 2009, approximately $210.0 million in total grant funding has been awarded to approximately 285 eligible entities. All of the outreach and enrollment grants share the common goal to help reduce the number of children who are eligible for Medicaid and CHIP but are not enrolled.

Legislative and Funding History

Congress has provided funding to improve outreach, education, and application assistance to enroll eligible, uninsured children in Medicaid and CHIP through several pieces of legislation. Section 201 of the CHIPRA (P.L. 111-3) provided $100.0 million for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to Indian Children. Section 10203 of the Patient Protection and Affordable Care Act (ACA) provided an additional $40.0 million. Section 303 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided an additional $40.0 million in FY 2016 through FY 2017. Section 3004 of the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2018 (referred to as the HEALTHY KIDS Act and included in P.L. 115-120) and Section 50103 of the Advancing Chronic Care, Extenders and Social Services Act (referred to as the ACCESS Act and included in P.L. 115-123) provided a combined total of $168.0 million for outreach and enrollment activities for FY 2018 through FY 2027. These programs conduct outreach and enrollment efforts designed to increase the enrollment of children who are eligible for Medicaid or CHIP.

Key Provisions of Authorizing Legislation and Grant Awards

The following sections provide an overview of the key provision of each of the authorizing pieces of legislation funding these outreach and enrollment grants, and the results of the

grant process.

CHIPRA

Of the $100.0 million provided by section 201 of CHIPRA, $80.0 million was appropriated for the Outreach and Enrollment Grants with an additional $10.0 million specifically dedicated to outreach and enrollment of American Indian/Alaska Native children (AI/AN) and $10.0 million for a national outreach campaign. The first $40.0 million in grant funds was awarded on September 30, 2009. CMS awarded 69 grants distributing $40.0 million in federal funds across 41 states and the District of Columbia. On April 16 2010, CMS awarded $10.0 million in grant funds to 41 health programs operated by the Indian Health Service, tribes and tribal organizations, and urban Indian organizations across 19 states for outreach and enrollment of uninsured AI/AN children into Medicaid and CHIP. On August 18, 2011, CMS awarded an additional $40.0 million in grant funds to 39 grantees across 23 states. These grants, entitled CHIPRA Outreach and Enrollment Grants (Cycle II), encouraged applicants to take a more systematic approach to outreach, enrollment, and retention. Grantees focused on five specific areas that had been identified as those most representing the opportunities and challenges for the enrollment and retention of children in health insurance coverage.

ACA and MACRA

As part of the $40.0 million provided by section 10203 of the ACA, CMS awarded the Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III) on July 2, 2013. CMS awarded $32.0 million in 41 grants to state agencies, community health centers, school-based organizations and non-profit groups in 22 states. On November 12, 2014, CMS awarded $3.9 million in grant funds to 10 grantees in seven states for outreach and enrollment of AI/AN children into Medicaid and CHIP.

MACRA extended the Outreach and Enrollment Program through FY 2017. It provided an additional $40.0 million, of which $32.0 million was dedicated to a fourth cycle of general outreach and enrollment grants. On June 13, 2016, CMS awarded 38 cooperative agreements in 27 states totaling just under the $32.0 million. Awards under these cooperative agreements funded activities aimed at educating families about the availability of free or low-cost health coverage under Medicaid and CHIP, identifying children likely to be eligible for these programs, and assisting families with the application and renewal process. The two year performance period for these awards ended June 30, 2018, but 18 grantees were granted no-cost extensions ranging between 1-12 months. MACRA also provided $4.0 million for outreach and enrollment of AI/AN children and $4.0 million for a national outreach campaign. On June 14, 2017, CMS awarded eight cooperative agreements in six states totaling just under $4.0 million. The two year performance period for these awards ended June 30, 2019.

HEALTHY KIDS and ACCESS Act

The HEALTHY KIDS Act provided $120.0 million for activities aimed at increasing the participation of eligible children in Medicaid and CHIP. Of the total $120.0 million in funding, 10 percent was set aside for outreach to AI/AN children ($12.0 million), 10 percent was set aside for the National Campaign ($12.0 million), and the remainder ($96.0 million) is dedicated to grants for the outreach and enrollment of uninsured children and their parents. On June 19, 2019, CMS awarded $48.0 million in cooperative agreements to 39

organizations in 25 states. The performance period for these awards is three years.

CMS is planning a second phase of $48.0 million for outreach and enrollment grants broadly targeting all eligible children in Medicaid and CHIP from FYs 2022 to 2025. Of the $12.0 million available for outreach and enrollment grants targeting the enrollment and retention of eligible AI/AN children in Medicaid and CHIP, CMS issued a NOFO to make available $6.0 million in cooperative agreements to eligibility entities on July 16, 2019. On January 13, 2020, CMS awarded nine new cooperative agreements, in six states, dedicated to the outreach and enrollment of AI/AN children.

Outreach to American Indian/Alaska Native Children

Section 2113(b)(2) of the Social Security Act set aside 10 percent of any amounts appropriated under that section to award grants to Indian health care providers to reduce the number of uninsured, low-income children in the United States through the enrollment and retention of eligible AI/AN children in Medicaid and CHIP. As noted above, on April 15, 2010, CMS awarded 41 grants for a total of $10.0 million. On November 12, 2014, CMS awarded a second round of Outreach and Enrollment Grants, from a $4.0 million Patient Protection and Affordable Care Act appropriation, to organizations serving Indian children. On June 15, 2017, CMS awarded eight new AI/AN cooperative agreements with $4.0 million in funds from MACRA. This set-aside also applies to appropriations provided in the HEALTHY KIDS and ACCESS Acts of 2018. Of the total $120.0 million in funding provided by the HEALTHY KIDS Act, CMS issued a notice of funding opportunity on July 16, 2019 to make available $6.0 million to eligible AI/AN entities. CMS announced these nine new awards on January 13, 2020. The performance period for these awards is three years.

National Enrollment Campaign

The statute sets aside 10 percent of appropriations to develop and implement a national enrollment campaign to increase the enrollment of eligible, uninsured children. Through the Connecting Kids to Coverage National Campaign (National Campaign), CMS has developed materials, such as posters, palm cards, and public service announcements, which include a call to action to enroll and retain children in Medicaid and CHIP, as well as their parents in Medicaid. National Campaign efforts have enhanced communications in target markets and with states, grantees, and other groups working on outreach and enrollment efforts through educational webinars and by distributing free tools that can be easily adapted to support these efforts.

With the funding appropriated under the HEALTHY KIDS Act of 2018, CMS awarded a multi-year task order in May 2019 to continue the National Campaign. The National Campaign continues to focus on informing families that their eligible children can enroll in Medicaid and CHIP any time of the year. Activities previously funded through the Campaign, such as conducting training webinars and meetings, developing newsletters on key topics for partners, creating and updating print materials to support outreach and enrollment efforts, and producing new public service announcements and social media graphics will be continued. In FY 2015 - FY 2019, CMS also developed PSAs for tribal communities and aired these on Good Health TV®, a health education program serving in tribal hospitals and clinic waiting rooms.

Budget Overview

CHIPRA appropriated a total of $100.0 million for fiscal years 2009 through 2013. Section 10203(d)(2)(E) of Patient Protection and Affordable Care Act provided an additional $40.0 million in FY 2010 and extended the period of availability of all funds through fiscal year 2015. Of the total appropriated amount, 10 percent was set aside for the national enrollment campaign and another ten percent was for AI/AN outreach. CMS awarded $40.0 million in FY 2009 for outreach grants and approximately $10.0 million in FY 2010 for general outreach to AI/AN children. CMS awarded an additional $40.0 million of the remaining grant funds under CHIPRA on August 18, 2011. Under the Patient Protection and Affordable Care Act, in July 2013, CMS awarded a third round of outreach and enrollment grants (totaling $32.0 million) entitled "Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III)" and then in November 2014, awarded a second round of Outreach and Enrollment Grants, totaling $4.0 million to organizations serving AI/AN children. The $10.0 million appropriated through CHIPRA in combination with the $4.0 million appropriated through the Patient Protection and Affordable Care Act have been used to fund National Enrollment Campaign efforts, as required under the statutes.

MACRA appropriated an additional $40.0 million in FY 2016. Of this appropriated amount, $32.0 million was set aside for outreach grants, $4.0 million was set aside for outreach and enrollment grants specifically dedicated to the outreach and enrollment of AI/AN children, and $4.0 million was set aside for the National Enrollment Campaign. These additional funds were available for obligation through FY 2017. For the National Enrollment Campaign, over $3.0 million was obligated in FY 2016. In FY 2017, the remaining funds were obligated.

The HEALTHY KIDS Act of 2018 appropriated $120.0 million over FY 2018 through FY 2023 to continue support for outreach grants, including grants dedicated to the outreach and enrollment of AI/AN children and the National Enrollment Campaign. The ACCESS Act of 2018 appropriated an additional $48.0 million from FY 2024 through FY 2027 and established an additional 10 percent set-aside for evaluation and technical assistance to grantees.

DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

Program Description and Accomplishments

Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) required the Secretary to establish a two-year demonstration program no later than January 1, 2016 that would increase the Federal Matching Percentages for participating states to improve access to behavioral health services.

HHS has submitted annual reports to Congress in which the program is assessed on the basis of quality, scope, impact, and the use of funds.

Budget Overview

Section 223 authorized and appropriated $2.0 million in FY 2014 and $25.0 million for the planning grants in FY 2016 to carry out this section. Amounts appropriated for this program

remain available until expended. In FY 2016, $25.0 million in appropriated planning grant funding for this demonstration underwent a 6.8 percent sequestration cut which reduced the budget authority available for the planning grants to $23.3 million.

On May 20, 2015, SAMHSA, in conjunction with CMS, released a Request for Applications (RFA) for Planning Grants to States that intended to participate in the section 223 Protecting Access to Medicare Act (PAMA) Demonstration Programs to Improve Community Mental Health Services. Planning Grant applications from states wishing to participate in the two year Certified Community Behavioral Health Clinic (CCBHC) Demonstration were due to SAMHSA on August 5, 2015, http://www.samhsa.gov/grants/grant-announcements/sm-16-001. On October 19, 2015, SAMHSA, in conjunction with CMS and ASPE, awarded approximately $22.9 million in planning grants to 24 states to support their efforts to improve behavioral health services under the Medicaid program by providing community-based mental health and substance use disorder treatment. SAMHSA, CMS, and ASPE provided robust technical assistance to grantee states throughout the FY 2016 one-year planning phase of the demonstration. When the planning grant phase ended in October 2016, eight states were selected to participate in the section 223 behavioral health demonstration to make services more widely available through certified community behavioral health clinics.

In December 2016, HHS, based on an application review by SAMHSA, CMS, and ASPE, announced the selection of the following eight states: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania to receive enhanced federal match for specific behavioral health services over a period of two years. Demonstration programs in selected states were launched between the months of April 1, 2017 to July 1, 2017. HHS will report to Congress annually with an assessment of the quality, scope, and impact, and use of funds by demonstration programs, with a final report submitted no later than December 2021, which provides recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223.

In October 2018, SAMHSA released the first annual Report to Congress which focuses on activities surrounding implementation of the demonstration, the one-year planning phase, states selected to participate in the 2-year demonstration and CCBHC program launch in the selected states. ASPE is continuing to conduct evaluations of the demonstration and is developing an Analysis Report to assess access to community-based mental health services under the Medicaid program, the quality and scope of services provided by CCBHCs, and the impact of the demonstration on federal and state costs of a full range of mental health services.

On April 18, 2019, H.R. 1839 Medicaid Services Investment and Accountability Act of 2019 (MSIA) P.L. 116-16 was signed into law which provided for a 90-day extension of Oklahoma and Oregon's CCBHC demonstration programs from 3/29/19 to 6/30/19. These states began their two-year demonstrations on April 1, 2017, 90 days prior to the additional six states. The MSIA allowed OK and OR to bring their program end date into alignment with Minnesota, Missouri, New York, New Jersey, Nevada and Pennsylvania's end date of June 30, 2019.

On July 5, 2019, S. 2047 A bill to provide for a 2-week extension of the Medicaid community mental health services demonstration program (P.L. 116-29) was signed into law which provided for a 2-week extension of the demonstration for all eight states from June 30, 2019 to July 14, 2019.

On August 6, 2019, P.L. 116-39 the "Empowering Beneficiaries, Ensuring Access, and Strengthening Accountability Act of 2019," was signed into law by the President. This legislation extends the section 223 demonstration from 7/14/2019 – 9/13/2019.

On September 27, 2019 HR 4378, P.L. 116-59, the "Continuing Appropriations Act, 2020, and Health Extenders Act of 2019," was sign into law, which extended the section 223 demonstration from September 13, 2019 to November 21, 2019.

On November 21, 2019, H.R. 3055, P.L. 116-69, the "Further Continuing Appropriations Act of 2020, and Further Health Extenders Act of 2019," was signed into law, which extended the section 223 demonstration from November 21, 2019 to December 20, 2019.

On December 20, 2019, H.R. 1865, P.L. 116-94, the Further Consolidated Appropriations Act, 2020 was signed into law, which extended the section 223 demonstration from December 20, 2019 to May 22, 2020.

ASPE will be leading the development of the remaining CCBHC Reports to Congress and on July 22, 2019, ASPE released the second CCBHC report for Congressional review. The 2018 report can be found on ASPE's website: https://aspe.hhs.gov/pdf-report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018.

DEMONSTRATION PROJECT TO INCREASE SUBSTANCE USE PROVIDER CAPACITY UNDER THE MEDICAID PROGRAM

Program Description and Accomplishments

Section 1003 of the SUPPORT for Patients and Community Act (P. L. 115-271) requires the Secretary to create a five-year demonstration for the purposes of increasing the number and ability of providers participating in Medicaid to provide treatment for substance use disorders. The Secretary of HHS shall conduct this demonstration under the authority of Title XIX.

For the first 18-month period of the demonstration project, the Secretary shall award planning grants to at least 10 states (based on geographic diversity, with a preference to states with a prevalence of opioid use disorders comparable to or higher than the national average) to conduct the following activities:

- Activities that support the development of a behavioral health needs assessment; and
- Activities that, taking into account the results of the assessment, support the development of state infrastructure to recruit prospective providers to treat substance use disorders and training for those providers.

For the remaining 36-month period of the demonstration, the Secretary shall select no more than five states (based on information submitted by the state in an application to the Secretary) to continue the demonstration, and to receive an FMAP of 80 percent for expenditures attributable to substance use treatment or recovery services that exceed one-fourth of funds expended by the state in FY 2018.

This provision also requires CMS (in consultation with the Director of the Agency for Healthcare Research and Quality and the Assistant Secretary for Mental Health and Substance Use) to submit an initial, interim, and final report to Congress based on annual reports received by the states on the outcomes of the demonstration. CMS shall issue the reports by the following dates:

- Initial Report: May 1, 2021
- Interim Report: May 31, 2023
- Final Report: May 31, 2025

CMS released a Notice of Funding Opportunity (NOFO) for planning grants for the demonstration to increase substance use treatment provider capacity in the Medicaid program on June 25, 2019.

CMS selected and awarded $48.5 million in planning grants to 15 states on September 18, 2019. The statutory date for awarding planning grants was April 24, 2019. The target dates were pushed back to allow adequate time for statutorily required collaboration and clearances.

Selected states had a State plan or approved waiver program, were geographically diverse, and had a prevalence of substance use disorder (in particular opioid use disorder) that was comparable to or higher than the national average prevalence.

The Agency for Healthcare Research and Quality and SAMHSA have met with and continue to collaborate with CMS on all activities to date.

Budget Overview

Section 1003 authorizes and appropriates $50.0 million for the planning grants and $5.0 million to support the administration of the demonstration in FY 2019 to carry out this section. Amounts appropriated for this program shall remain available until expended.

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Information Technology

(Dollars in thousands)

Information Technology Portfolio	FY 2019 Enacted	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 (+/-) FY 2020
Program Management	***$ 1,913,444***	***$ 1,818,935***	***$ 1,401,072***	***$ (417,863)***
Federal Administration	$ 47,681	$ 41,027	$ 44,392	***$ 3,365***
Program Operations	$ 1,280,461	$ 1,222,659	$ 848,879	***$ (373,780)***
Research /1	$ 3,000	$ 4,203	$ -	***$ (4,203)***
Survey & Certification	$ 1,183	$ 1,182	$ 9,000	***$ 7,818***
Subtotal: Discretionary Appropriation	*$ 1,332,325*	*$ 1,269,071*	*$ 902,271*	***$ (366,800)***
ACA Section 2701	*$ 482*	*$ 3,721*	*$ 1,566*	***$ (2,155)***
MACRA Section 101	$ 53,217	$ 31,261	$ -	***$ (31,261)***
MACRA Section 501	$ 17,529	$ 4,709	$ 91	***$ (4,618)***
Medicaid (4201)	$ 2,949	$ 4,307	$ 4,454	***$ 147***
Medicare (4101, 4102)	$ 6,421	$ 8,005	$ 5,710	***$ (2,295)***
PAMA Section 210 & 216	$ 2,515	$ 4,831	$ 3,400	***$ (1,431)***
Subtotal: Mandatory Appropriation	*$ 83,113*	*$ 56,834*	*$ 15,221*	***$ (41,613)***
CLIA	$ 4,050	$ 4,050	$ 4,050	***$ -***
COB User Fees	$ 23,527	$ 26,613	$ 29,693	***$ 3,080***
Exchange Risk Adjustment User Fees	$ 18,635	$ 21,369	$ 15,837	***$ (5,532)***
Exchange User Fees	$ 438,412	$ 427,616	$ 415,000	***$ (12,616)***
RAC MSP & Parts A/B	$ 13,382	$ 13,382	$ 19,000	***$ 5,618***
Subtotal: Offsetting Collections	*$ 498,006*	*$ 493,030*	*$ 483,580*	***$ (9,450)***
Quality Improvement Organizations /2	***$ 212,806***	***$ 313,500***	***$ 276,400***	***$ (37,100)***
QIO - Programmatic Contracts	$ 167,661	$ 226,300	$ 191,900	***$ (34,400)***
QIO - Support Contracts	$ 45,145	$ 87,200	$ 84,500	***$ (2,700)***
Innovation Center	***$ 199,354***	***$ 174,623***	***$ 179,985***	***$ 5,362***
Health Care Fraud & Abuse	**$ 521,813**	**$ 407,556**	**$ 459,367**	***$ 51,811***
Mandatory	$ 223,949	$ 161,160	$ 164,682	***$ 3,522***
Discretionary	$ 297,864	$ 246,396	$ 294,685	***$ 48,289***
Total Information Technology Portfolio /3	**$ 2,847,417**	**$ 2,714,614**	**$ 2,316,824**	***$ (397,790)***

/1 In FY 2021, CMS proposes to request Research funding within the Program Operations account.
/2 Pending approval of QIO 12th scope of work.
/3 Totals may not add due to rounding.

Program Description

The Information Technology (IT) portfolio provides funding for all IT investments that support CMS operations. IT encompasses funding for the processing of Medicare Fee-For-Service (FFS) claims as well as infrastructure and operational support. It supports the Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement activities, and ongoing research. It also funds operations and enhancements in the Medicaid and CHIP programs and other areas such as insurance market reform, oversight, and operational contracts supporting the Exchange. A key aspect of administering these programs is to ensure the security of CMS' data and IT infrastructure. In addition, IT supports CMS' efforts to decrease program payment error rates and increase the program integrity return on investment (ROI).

CMS continues to focus on implementing a cloud hosting environment throughout the agency, while refining the single point of entry. Shifting CMS' IT infrastructure to the cloud will make the agency's operations more cost effective, make collaboration more efficient, and allow for business scalability. CMS contracts with Amazon Web Services (AWS) and Microsoft Azure Government (MAG) to provide CMS' cloud hosting environment. There are currently 80 different applications running on AWS or MAG throughout the agency. Starting in FY 2019, just for the Exchange applications, CMS migrated 25 systems, 33 environments (development, testing, implementation, UAT, and production), and over 700 Terabytes to the cloud. CMS has also developed a Data Center Optimization Initiative (DCOI) Strategic Plan. The foundation of the DCOI is to maximize efficiencies through outreach, collaboration, and education to guide agency users in the adoption and implementation of cloud offerings.

This chapter covers Agency-wide IT spending across all funding sources and programs. The intention is to provide a portfolio view of major CMS IT investments to show how these investments relate to specific activities. While this chapter focuses on major investments, multiple non-major investments support each of the activities as well. Additional information on specific IT investments can be viewed at the IT Portfolio Dashboard located at the following web address: https://www.itdashboard.gov/drupal/summary/009

Funding History

Fiscal Year	Budget Authority
FY 2017	$2,581,419,000
FY 2018	$2,944,097,000
FY 2019	$2,685,606,000
FY 2020 Enacted	$2,714,614,000
FY 2021 President's Budget	$2,316,824,000

FY 2021 IT Funding Level: $2,263.3 million

The FY 2021 funding level for CMS-wide IT is $2,316.9 million, a decrease of $397.8 million below the FY 2020 Enacted level. This funding supports all CMS essential IT investments. Below are three of CMS' top priorities within the IT portfolio that account for $128.4 Million of the total request.

IT Security ($96.5 million) - CMS faces a growing cybersecurity threat every day due to the value of the data we safeguard and the increased technical capacity of "bad actors" across the globe. CMS has maintained a robust IT security program, however, the increased threat coupled with the outdated security infrastructure maintained within the agency requires CMS to continue to prioritize this investment. CMS has successfully implemented Continuous Diagnostics and Mitigation (CDM) at the core data center and has progressed beyond the Baltimore Data Centers, targeting Data Centers containing high value assets and large numbers of FISMA systems. It will take multiple years and additional resources in order to comply with OMB's mandate to fully implement CDM across the entire landscape, establish and maintain ongoing authorization, automate Indicators of Compromise (IOCs) sharing with data centers, and, increase the viability of cloud security and the Development Security Operations programs. OMB and HHS have accelerated the

timeline for all CDM phases, which means CMS will need to plan and execute multiple CDM phases simultaneously. The FY 2021 request of $96.5 million includes $86.5 million of Program Operations funding, along with $7.7 million of Exchange funding, $0.9 million of Federal Administration and $1.4 million in Program Integrity/Innovation Center funding. This funding will be used for CMS to expand on its CDM work at the new accelerated pace. Protecting beneficiary data has been and will remain a top priority at CMS.

Medicare Payment Systems Modernization (MPSM) ($15.9 million) - The Medicare FFS Claims processing systems, otherwise known as the FFS shared systems, were developed on the mainframe over 40 years ago and CMS continues to add on to those systems to meet critical Medicare business needs. These claims processing systems were written in legacy COBOL and Assembler programming languages and have not been modernized since their inception. As the Medicare program has continued to evolve, CMS has recognized that these systems will not be able to keep up with the changing needs of the program and regulations. A fundamental technological system change is necessary to support both existing payment models with the influx of covered beneficiaries and to provide flexibility for various value-based payment models as they are conceived and implemented. The MPSM initiative is a multi-year effort.

CMS had engaged its Medicare Contractor software developers, the United States Digital Services, and procured new vendors through a Blanket Purchase Agreement whose expertise includes cloud development, agile development and delivery, and a modern holistic focus on human-centered design. We have developed new Application Programming Interfaces (APIs) that facilitate more efficient use of data by our current claims processors with the potential to serve other systems and users in the future. We have programmed key pieces of CMS pricing software in Java and deployed that on the Cloud. This has improved our ability to react to problems quickly and efficiently, with a case example yielding a 50% reduction in time-to-fix. Lastly, we have laid an operational foundation to support current and future work, introduced automated monitoring tools for both cloud and mainframe activity, and are continually exploring technical innovations and tools to support the overall modernization effort. This funding will be used to continue these efforts, expanding APIs and offering more pricing as a Service in the Cloud, Prototyping additional services and technology, and for additional modernization of pieces of payment system functionality that will be determined through current research and design.

Continuity of Operations Disaster Recovery (COOP DR) ($16.0 million) - CMS is undergoing a revitalization of the agency-wide COOP program to improve CMS' recovery posture and operational capability. Recent audit findings have determined the programs and systems that support CMS Mission Essential Functions (MEFs) require increased capabilities to meet federal requirements. This funding will address gaps identified in the CMS COOP program and allow systems supporting CMS MEFs to have improved disaster recovery (DR) capability. Specifically, this funding will allow CMS to migrate to the cloud environment to enhance our COOP DR capacity, modernize old code, and promote efficiencies in processing. Funding will also be used to enhance the testing, training and exercising element of the COOP DR program to further validate appropriate recovery strategies.

Information Technology Portfolio Budget
By Investment Category
(Dollars in thousands)

IT Funding by Category	FY 2019 Enacted	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 (+/-) 2020
Medicare Parts A & B	$ 666,289	$ 764,152	$ 731,813	*$ (32,339)*
Medicare Parts C & D	$ 162,819	$ 121,406	$ 116,864	*$ (4,542)*
Medicare Outreach & Education	$ 66,935	$ 70,742	$ 89,587	*$ 18,845*
Medicaid and the Children's Health Insurance Program	$ 77,702	$ 44,373	$ 78,800	*$ 34,427*
Federal Exchanges	$ 627,620	$ 612,358	$ 430,837	*$ (181,521)*
Health Care Quality	$ 76,174	$ 136,528	$ 82,391	*$ (54,137)*
Enterprise IT	$ 1,169,878	$ 965,055	$ 786,532	*$ (178,523)*
Total IT Portfolio	**$ 2,847,417**	**$ 2,714,614**	**$ 2,316,824**	*$ (397,790)*

/1 Totals may not add due to rounding.

Medicare Parts A & B

Medicare Parts A & B investments support the Fee-For-Service (FFS) and durable medical equipment (DME) claims processing operations. For these activities, CMS acts as a traditional insurance company by verifying beneficiary eligibility, enrolling providers and suppliers, and processing and paying out claims. Additionally, CMS administers a number of incentive payment programs that reward eligible providers for improving quality, reducing unnecessary resource utilization, and adopting new technologies.

Funding Level: $731.8 million

The FY 2021 funding level for Medicare Parts A and B investments is $731.8 million, a decrease of $32.3 million below the FY 2020 Enacted level. The decrease can be attributed to operational efficiencies in the cloud migration strategy.

Beneficiary Enrollment: CMS processes Medicare beneficiary enrollment and defines eligibility status. CMS works in coordination with the Social Security Administration (SSA) to verify eligibility, effectuate enrollment, and ensure that premiums are collected. CMS also works with the Railroad Retirement Board (RRB) to manage beneficiaries who receive assistance through those programs. These operations ensure consistent information on enrollment status, including whether premium payments are up-to-date, and that CMS makes appropriate claims payments.

- *Medicare Beneficiary Enrollment Data Management Systems* – These systems provide the authoritative source for Medicare beneficiary eligibility and enrollment status, ensuring that only claims for valid beneficiaries are paid. CMS manages the billing and collection of premiums for both beneficiaries and third party payers. In coordination with investments in *Beneficiary Enrollment and Plan Payment for Part C & D,* CMS ensures beneficiaries are appropriately enrolled in the various types of insurance coverage offered by the agency.

Provider Enrollment: These investments allow providers and suppliers to enroll in Medicare by verifying their eligibility to participate. In addition, they support collecting required information, establishing billing relationships, and screening providers to flag potential fraudulent actors.

- *Interoperability & Standardization - Provider Enrollment Chain and Ownership System (PECOS)* – Provides the authoritative national repository of all enrolled Medicare and Medicaid providers and suppliers. Entities providing payment under Medicare are required to verify provider participation before issuing payment. This PECOS investment includes collecting and maintaining data on initial enrollment, changes of information, reassignments, and mandated revalidations or re-enrollments. CMS collects information about ownership, authorized officials, delegated officials, managing employees, practice locations, practice types, and affiliated provider information.

- *Advanced Provider Screening* – Aggregates data from multiple sources to conduct pre- and post-enrollment provider screening. This investment provides the ability to both prospectively and retrospectively assess program eligibility criteria, as well as provide additional data to further assess provider eligibility in Medicare and Medicaid, such as automatically running criminal background checks. By flagging potentially ineligible providers, CMS can take appropriate action to eliminate a potential source of fraud, waste, and abuse.

Claims Processing: Medicare FFS relies on multiple IT investments running on an integrated infrastructure to successfully process and pay claims. Claims processing includes investments that support processing appeals and ensures that Medicare is the most appropriate payer. CMS conducts extensive testing to ensure this suite of investments operates efficiently and effectively.

- Medicare Shared Systems (MSS) – Supports a common environment for operating legacy claims processing systems for inpatient hospital services, outpatient services, and DME. A single data source with full individual beneficiary information allows contractors to verify beneficiary eligibility, conduct pre-payment review, and approve claims. These investments support the receipt of claims, editing, pricing, adjudication, correspondence, on-line inquiry, file maintenance, financial processing, and reporting. This investment captures the Certificate of Medical Necessity and supplier interfaces specific to DME claims. Claims are screened through the Fraud Prevention System (FPS), to identify potential waste, fraud, or abuse.

- HIPAA Eligibility Transaction System (HETS) – Allows providers to check beneficiary eligibility for Medicare Part A and B services using HIPAA-compliant Accredited Standards Committee (ASC) X12 transactions. HETS processes close to 1.5 billion transactions per year.

- Medicare Appeals System (MAS) – Provides a unified appeals case-tracking system that facilitates maintenance and transfer of case-specific data with regard to FFS and Managed Care appeals. MAS is capable of docketing hearings, scheduling expert witnesses for testimony, compiling case notes, and facilitating adjudication. In addition, MAS provides the capability to report on appeals data, enabling more

accurate and expedient reporting and allowing for more precise assessments and policy-setting.

- Medicare Secondary Payer System (MSPS) – Ensures proper benefits coordination and payment recovery when Medicare is not the primary payer. MSPS collects and processes data from other insurers and employers, allowing CMS to make more accurate primary and secondary payment decisions.

- Fraud Prevention System (FPS) – Provides state-of-the-art analytical tools to help predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. Before Medicare fee-for-service claims are approved for payment, they are processed through FPS to identify high-risk claims for further review. Proven predictive models are used in risk scoring to generate alerts and triangulate the results to identify high-risk claims and providers.

Incentive Payment Programs: Providers and some suppliers can be eligible for payment adjustments based on participation in a variety of incentive programs. The most significant change to these programs in recent years is the Quality Payment Program (QPP), which replaced the previous physician incentive programs with a two-track system designed to modernize provider quality reporting and encourage participation in Alternative Payment Models (APMs).

- *Quality Payment Program (QPP)* – Includes two tracks for clinicians under Medicare, one through the Merit-based Incentive Payment System (MIPS), which adjusts clinicians' payment based on performance on cost, quality, improvement activities, and promoting interoperability, and one through participation in Advanced APMs. Clinicians who reach a certain level of participation in Advanced APMs are eligible for a 5 percent incentive payment from 2019 through 2024 and a higher payment update under the Medicare physician fee schedule starting in 2026. Implementing the QPP involves a significant investment to develop a single reporting portal that will allow participating clinicians to better understand the program, submit data, and review their information.

- *Hospital Quality Reporting (HQR) System* – Supports the collection and analysis of quality measures from participating hospitals in order to make appropriate payment adjustments based on performance.

- *Accountable Care Organizations (ACOs)* – Support the Medicare Shared Savings Program by providing ACO eligibility verification and beneficiary assignment, and by calculating annual expenditures, performance and quality scores, and shared savings.

- *End Stage Renal Disease (ESRD) Quality Reporting System* – Provides a comprehensive ESRD patient registry that tracks services provided to ESRD beneficiaries for calculating performance-based payments.

Medicare Parts C and D

Medicare beneficiaries have the option of purchasing prescription drug coverage or combining some or all of their coverage options through private issuers. Prescription drug coverage (Part D) and Medicare Advantage (Part C) have different operational profiles and present different challenges than Parts A and B. Instead of interacting with and paying providers through the claims process, CMS interacts and pays private issuers through specifically designed IT systems. Business processes and IT systems are designed to manage beneficiary enrollment, ensure issuer compliance with benefit design parameters, manage special benefits, and balance risk across issuers.

Funding Level: $116.9 Million

The FY 2021 funding level for Medicare Part C and D IT investments is $116.9 million, a decrease of $4.5 million below the FY 2020 Enacted level. This funding continues to support the Agency's mission of serving beneficiaries through the investments listed below:

Beneficiary and Plan Management: Ensures that beneficiaries are able to enroll in Part C and D coverage. CMS works extensively with private issuers to review their plans, collect data, and ensure proper payment.

- *Beneficiary Enrollment and Plan Payment for Parts C and D* – Delivers enrollment and health plan payment for approximately 40 million Parts C and D enrollees. This investment is dependent upon certain beneficiary demographic and entitlement data in the *Medicare Beneficiary Enrollment Data Management* systems. CMS maintains, updates, tests, and monitors system operations for enrollment and payment functions, and provides technical assistance and customer service associated with audits and compliance.

- *Health Plan Management System (HPMS)* – Manages the day-to-day interactions with about 880 private plan contractors who are offering plan options to beneficiaries. Participating contractors can submit applications, bids, formulary submissions, marketing material reviews, and plan oversight documents, as well as manage complaints, review enrollment and payment data feeds, and maintain data for the Medicare & You handbook and Medicare Plan Finder. This system also supports the annual plan bidding process, ensuring that issuers comply with regulatory requirements such as no-cost preventive services.

Drug Subsidies: Many Medicare beneficiaries enrolled in Part D are entitled to discounts and rebates through various programs. These investments ensure that beneficiaries receive the correct discounts and support enrollees in managing out-of-pocket expenses.

- *Drug Claims Processing System (DCPS)* – Collects, processes, and stores data from Part D claims to ensure the appropriate payment of covered drugs. Records are submitted electronically on a monthly basis and validated through automatic and manual edits. The claims are used during the payment reconciliation process in order to compare actual expenditures, including discounts for applicable drugs provided at the point-of-sale, to prospective payments made during the year. CMS coordinates the collection of discount payments from manufacturers and participating issuers.

- *Coordination of Benefits/True Out-of-Pocket (TrOOP)* – Provides real-time primary and secondary coverage information to pharmacies and Part D plans via pharmacy industry telecommunications systems. This investment provides eligibility and coverage information to pharmacies to enable real-time billing, and routes information on payments made by secondary payers back to the Part D plans.

Risk Adjustment: Ensures that each Medicare private plan issuer's risk is adjusted based on the medical experiences of individuals enrolled in their plans. Risk adjustment ensures that participating plans are not incentivized to select for healthier enrollees by transferring premiums from low to high-risk issuers.

- *Risk Adjustment Data Collection* – Calculates the risk scores for over 60 million beneficiaries. Multiple risk adjustment factors are created by analyzing the diagnosis history for each beneficiary and using statistical models to adjust the risk experienced by each Part C & D plan. The risk factors are provided to HPMS for initial, mid-year, and final reconciliation payments, as well as reruns of prior years to process overpayments.

- *Encounter Data System* – Collects beneficiary level, per-visit health care encounter data from participating issuers to enable calculation of risk coefficients that accurately reflect the demographics, patterns of care, and the predicted costs of diseases for Part C enrollees.

- *Central Data Abstraction Tool (CDAT)* – Collects diagnosis information from participating issuers to support the risk adjustment data validation (RADV) audits. CMS uses the results of these audits to estimate and recover overpayments.

Medicare Outreach & Education

Medicare Outreach and Education IT systems support the National Medicare Education Program (NMEP). Beneficiary e-Services creates a virtual, enterprise-wide, multi-contact channel for handling beneficiaries' inquiries that maximizes resources and service effectiveness. These systems support medicare.gov and cms.gov websites.

Funding Level: $89.6 Million

The FY 2021 funding level for Medicare Outreach and Education is $89.6 million, an increase of $18.8 million above the FY 2020 Enacted level. The increase in funding will continue to support upgrades and maintenance to the medicare.gov and cms.gov websites to continue system improvements that provide beneficiaries the highest quality information possible.

- *Beneficiary e-Services* – Provides a virtual, enterprise-wide, one-stop service for handling Medicare beneficiary inquiries from multiple channels to meet the unique needs of our beneficiary population. Beneficiaries can contact CMS through beneficiary websites and portals, such as medicare.gov, and the Beneficiary Contact Center that handles phone, written, and email communications. Using the Next Generation Desktop application, these processes can access CMS data systems to answer Medicare inquiries on enrollment, claims, health care options, preventive services, and prescription drug benefits. The websites offer beneficiaries interactive tools like Medicare Plan Finder and Nursing Home Compare, as well as personalized

information such as enrollment, preventive services, claims, and prescription drugs. The Beneficiary Contact Center uses an interactive voice response system to provide beneficiaries with automated self-service information and options. Based on selections made, if the automated system cannot solve the caller's request, they are routed to the next available and best qualified customer service agent to resolve their inquiry.

- *Medicare and Medicaid Financial Alignment* – Supports the implementation of State programs to integrate care for individuals enrolled in both Medicare and Medicaid. This investment focuses on technical assistance to the States who are engaged in this effort by creating and providing necessary Medicare data files, as well as guidance on the request process and the use of Medicare data.

Medicaid and the Children's Health Insurance Program (CHIP)

CMS serves as the operational and policy center for the formulation, coordination, and evaluation of national policies and operations for Medicaid and CHIP. Investments in data infrastructure and systems ensure an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims. This data is used to produce statistical reports, support research, and assist in the detection of fraud, waste and abuse.

Funding Level: $78.8 million

The FY 2021 funding level for Medicaid and CHIP IT is $78.8 million, a $34.4 million increase above the FY 2020 Enacted level. At this funding level, CMS will continue to support the development of public use files and increased data sharing amongst the States within Medicaid and CHIP Business Information Solutions (MACBIS). This work will continue to replace the aging Medicaid financial system, and build new tools that allow CMS and States to collaborate online to process State Plan Amendments, waivers, reports on quality measures, demonstrations, advance planning documents, and other initiatives. CMS is also deploying a Medicaid and CHIP (MAC) Scorecard initiative that will consolidate and display State-level performance data in an easy-to-use format allowing for meaningful comparisons.

- *Medicaid and CHIP Business Information Solutions (MACBIS)* – Provides the data infrastructure and environment to facilitate collection of State-level programmatic claims data, including managed care options, beneficiary, and provider data. MACBIS automates the State plan approval process by collecting programmatic data on State Medicaid and CHIP operations. State plans support evaluation activities and ensure States remain in compliance with policies or waivers. Further, the investment supports a data analytics infrastructure for operational data about recipients, providers, claims, and encounters. This allows the States and CMS to better identify fraudulent activities and to integrate data across programs.

There are four major information technology upgrades under MACBIS. First, the request supports ongoing operations and maintenance of the Transformed Medicaid Statistical Information System (TMSIS). Both GAO and the HHS OIG have identified the availability of quality claims and encounter data through TMSIS as a necessity of auditing and investigations and as a top priority for the Medicaid program. Second, the request supports completion of the Medicaid drug rebate system rebuild, which is critical to adequate

oversight of the Medicaid drug rebate program. Third, the request supports continued work to replace the aging Medicaid financial system that tracks state financial reporting and administrative spending. And finally, the request will support the rollout of additional authorities in the Medicaid and CHIP Program (MACPro) system, which is a state-facing portal to capture states' submissions of state plan amendments, waivers, quality measures, advanced planning documents, and other documents. These MACBIS systems will give users improved access to data quality tools for analysis and evaluation for more informed decision making; allow for easier identification of priority, missing, and anomalous data; and enhance internal and external program monitoring and oversight.

- *Medicaid Data Information System* – Provides comprehensive data warehouse services with standardized enrollment, eligibility, and paid claims of dual-eligible, Medicare-Medicaid beneficiaries.

Federal Exchanges

CMS is responsible for operating the Federally-facilitated Exchange in States that don't set up their own State-based Exchange. The Federally-facilitated Exchange enables consumers to compare health plan options, receive eligibility determinations for a number of health insurance programs, obtain financial assistance with premiums and cost-sharing, and shop and compare health insurance plans.

Funding Level: $430.8 million

The FY 2021 funding level for Federal Exchange IT is $430.8 million, a decrease of $181.5 million below the FY 2020 Enacted level. The funding supports:

- *Health Insurance & Oversight System (HIOS)* – Provides participating issuers with a common portal to submit a range of information regarding health plans offered on the Exchanges. Issuers can submit health plan rates, benefits, and supporting information for display on healthcare.gov. Issuers also submit Medical Loss Ratio calculations, rate review justifications, quality information, and state regulatory data.

- *Federally-Facilitated Exchange (FFE)* – Provides a common platform for consumers and issuers to join together to provide coverage. Consumers can shop and enroll in coverage using easy plan compare tools based on price, benefits, services, and quality. The FFE provides comprehensive services to issuers for managing qualified health plan information, reconciling enrollment, and ensuring accurate payments. This investment also provides automated eligibility verification services facilitating access to multiple Federal, Medicaid, and private data sources.

- *Multidimensional Insurance Data Analytics System (MIDAS)* – Provides an integrated data repository for capturing, aggregating, and analyzing information on health insurance coverage. The data is used to monitor, forecast, trend, analyze, and report on the individual and small group health insurance markets.

- *Health Care Web Support* – Supports the individual portal for consumers to access the Health Insurance Exchanges. The systems, tools, and applications included in the portal help users compare, enroll in, and change their healthcare plans.

- *Eligibility Appeals Case Management System (EACMS)* – Ensures CMS is able to receive, process, and monitor appeals submitted by individuals, employers, and States who have delegated authority to CMS. EACMS provides a centralized point for the collection and review of appeals requests and supporting documentation including the secure transfer of case data between coordinating entities.

Health Care Quality

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through a variety of health care quality initiatives.

Funding Level: $82.4 million

The FY 2021 funding level for Health Care Quality IT is $82.4 million, a decrease of $54.1 million below the FY 2020 Enacted level. The decrease in funding is due to above average costs in FY 2020 for QIO systems contracts that required upfront financing. The FY 2021 funding level will continue the development, testing, integration, and maintenance of the physician value requirements. The requirements within the Physician Quality Reporting System (PQRS) are submitted by physicians and used to report quality data. This funding also supports upgrades to the Medicare physician resource reporting system.

- *Health Care Quality Improvement and Evaluation System (QIES)* – QIES is the key source of CMS quality data, aggregating data from State Survey Agencies, Federal contractors, and QIOs to support research, analysis, and beneficiary information such as the Nursing Home, Home Health, and Hospital Compare websites.

- *Quality Enterprise Services* – Provides a common architecture and system for the submission, parsing, staging, and processing of data from multiple quality programs to allow for streamlined measure reporting and calculation.

- *Quality Improvement Organizations (QIO) Information Systems* – Supports collaboration within the QIO community, coordination between CMS and the QIOs, and data collection to support operational analytics to improve the quality of care nationwide.

- *Innovation Core Systems* – Provides core IT systems that support models and demonstrations to manage their specific needs. Investments support a variety of activities, including beneficiary and provider enrollment, managing data collection, conducting analysis, and assisting in model evaluations.

Enterprise Information Technology

Enterprise IT encompasses investments which span multiple program areas or provide CMS-wide services. Examples of enterprise-wide investments are those associated with dual-eligible, Medicare-Medicaid beneficiaries, as well as program integrity activities that integrate data from across CMS to identify bad actors. Other investments focus on providing CMS-wide support and solutions to ensure operating and security standards are applied across CMS. These activities achieve economies of scale and allow for business owners to reuse existing processes to reduce cost.

Funding Level: $786.5 Million

The FY 2021 funding level for Enterprise IT is $786.5 million, a decrease of $178.5 million below the FY 2020 Enacted level. Funding in FY 2021 will continue ongoing IT operations, including making necessary investments in existing systems that support the effectiveness and efficiency of CMS operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies. These solutions continue to maximize operational efficiencies through IT modernization and cloud migration.

This funding also supports necessary investments in existing systems, such as upgrades to key data centers and enterprise-wide software licenses. CMS will continue making these functional enhancements designed to optimize user interfaces, while facilitating improved compliance.

Healthcare Integrated General Ledger Accounting System (HIGLAS) – Provides a centralized and integrated dual-entry accounting system that standardizes financial accounting functions for all CMS programs.

Infrastructure and Data Management: Supports core IT infrastructure and data management for use across CMS.

- *IT Infrastructure Ongoing Operations* – Provides vital infrastructure and services to CMS employees, researchers, contractors, and beneficiaries, including unified voice, video, and data technologies. This category of investments also supports overall management of data center resources by providing single, virtual entry for accessing hosting and technology offerings, such as private cloud technologies, standardization of architecture, and service management. Other activities in this category include supporting day-to-day operations of the mainframe, network, voice, and data communications, as well as backup and disaster recovery of mission critical applications. This investment provides an enterprise approach for managing information security and privacy, and supports the Large Scale Data Repository (LSDR), allowing for a robust, stable, and effective data repository environment.

- *Information Management and Analysis* – Supports data lifecycle management by providing guidance and technical assistance in the development, maintenance, administration, and enforcement of data asset reuse and metadata standards for over 820 databases. This investment also assures system performance, data availability, communication, and disaster recovery capabilities. Additionally, it supports coding changes and technical support for ongoing operations of legacy COBOL-based systems.

- *Systems Security* – Ensures that IT systems and data are adequately protected and meet IT security requirements. This investment includes required security control assessments and necessary employee security trainings, and also ensures that the Medicare Administrative Contractor (MACs) meet security requirements. Systems security investments also provide a full-time, enterprise cyber risk management program to maintain situational awareness of cyber threats and enables leadership to make informed decisions.

- *Integrated Data Repository (IDR)* – Provides a multi-view data warehouse orientation that is capable of integrating data on beneficiaries, providers, health plans, claims, and prescriptions, without relying on voluminous raw data extracts. The IDR provides a scalable system to meet current and expanding data volumes.

- *Chronic Condition Warehouse (CCW)* – Provides a centralized research database that combines Medicare, Medicaid, and Part D Prescription Drug Event data for individuals with chronic conditions readily available to support research activities. The CCW contains data dating back to 1999 for Medicare FFS, eligibility and enrollment, and assessments. The data is linked by a unique, unidentifiable beneficiary key, which allows researchers to analyze information across the continuum of care.

Shared Services: Provides CMS with cost-effective solutions that eliminate duplication by providing services that can be accessed across the various investments. These solutions provide standardized interfaces and reusable processes.

- *Enterprise Identity Management (EIDM)* – Ensures individuals have secure, authorized access to CMS business applications by providing a single point of entry and conducting remote identity proofing to confirm individual identities.

- *Master Data Management (MDM)* – This master directory provides a common identifier, which allows CMS to link and aggregate beneficiary, provider, program, and organization data from contrasting sources to create a trusted and authoritative data source. MDM is available to other investments, business processes, and applications, ensuring consistent display across CMS.

- *Enterprise Portal* – Provides a common portal for beneficiaries, providers, organizations, and States to access information and applications based on their roles and permissions. The portal combines and displays content and forms from multiple applications, and supports users with easy navigation, cross-enterprise search tools, simplified sign-on, and personalized, role-based access.

Crosscutting Program Integrity: Supports CMS-wide efforts to combat waste, fraud, and abuse by linking data across CMS programs via comprehensive and integrated investments that allow for better analysis and identification of bad actors.

- *Electronic Submission of Medical Documentation* (ESMD) – Allows providers to electronically submit medical documentation in support of medical review and audit efforts in Medicare.

- *Open Payments* – Collects information on payments from drug and device companies to physicians and teaching hospitals for things like travel, research, gifts, speaking fees, and meals. This includes ownership interests of physicians or their immediate family members in these companies. Applicable manufacturers and Group Purchasing Organizations are required to report an annual basis. The data is publically available in an easy to use, searchable, and downloadable format.

- *Healthcare Fraud Prevention Partnership (HFPP)* – Provides an opportunity for private and public payers to collaborate on health care fraud identification and prevention activities.

- *One Program Integrity (One PI)* – Provides an integrated data warehouse, which enables state Medicaid data to be combined with claims data from Medicare Parts A, B, and D. This allows for improved analytics to detect fraud, waste, and abuse activities across multiple Medicare programs.

- *The Unified Case Management System* – Serves as a central repository for contractor workload reporting, dashboards to monitor progress, and outcome measure calculations. This investment strategically positions CMS for a coordinated approach to Medicare and Medicaid audits and investigations.

Federal Exchanges
(Dollars in Thousands)

Treasury Account	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget	FY 2021 President's Budget +/- FY 2020 Enacted
Program Management	$1,636,111	$1,720,937	$1,171,728	($549,209)
Discretionary Appropriation	$263,895	$296,533	$0	*($296,533)*
Program Operations (non-add)	*$229,384*	*$268,937*	*$0*	*($268,937)*
Federal Administration (non-add)	*$34,511*	*$27,596*	*$0*	*($27,596)*
Offsetting Collections	$1,351,893	$1,399,404	$1,171,728	($227,676)
Federally-facilitated Exchange User Fee (non-add)	*$1,304,458*	*$1,341,039*	*$1,120,199*	*($220,840)*
Risk Adjustment User Fee (non-add)	*$47,435*	*$58,365*	*$51,530*	*($6,836)*
Other	$20,323	$25,000	$0	($25,000)
Heath Care Fraud and Abuse Control	$19,256	$63,918	$25,384	($38,534)
Discretionary Appropriation	$19,256	$63,918	$25,384	($38,534)
Total, Program Level	**$1,655,367**	**$1,784,855**	**$1,197,112**	**($587,743)**

*NOTE: The FY 2019 Final and 2020 Enacted levels are estimates as of January 2020.

Authorizing Legislation – Patient Protection and Affordable Care Act (Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152)

Allocation Method – Direct, Contracts, and Competitive Grants

Program Descriptions and Accomplishments

CMS is responsible for operating the Federally-facilitated Exchange (FFE) in States that elect to not set up their own State-based Exchange (SBE). SBEs can partner with CMS to leverage federal platforms for activities such as enrollment. These Exchanges are referred to as State-based Exchanges on the Federal Platform (SBE-FPs).

The Exchanges allow individuals to compare health plan options, determine eligibility for a number of health insurance programs, obtain financial assistance with premiums, and facilitate enrollment. Under the FY 2021 President's Budget, Federal Exchanges will be nearly 100% funded from user fees to make operations self-sustaining while building on continued contract efficiencies, including savings from the transition of IT infrastructure to the Cloud, plan management modernization, and the planned transition of three states (NJ, PA, and ME(SBE-FP)) from the Federal Exchange to State-based Exchanges in plan year 2021.

CMS has worked with states and the private sector to stabilize premiums for health plans offered on Federal Exchanges and bring more insurers back into the individual market. In 2020, for a second consecutive year, individual market conditions have improved. The 2020 premium for the average Federal Exchange second lowest cost silver plan, also known as the benchmark plan premium, decreased by four percent. This reduction follows a one percent decrease form 2018 to 2019. In total, 27 out of 38 states on the Federal Exchange are seeing decreases in the benchmark premium, and six states are experiencing double digit percentage declines in premiums. More issuers are entering the market and the number of states with just a single monopoly issuer is declining. Only two states have a single issuer in 2020, compared to five in 2019 and 10 in 2018.

In FY 2021, CMS will continue to conduct the following core responsibilities on behalf of all Exchanges:

- Verifying consumers' eligibility data for financial assistance through the Exchange or other health insurance programs, including Medicaid and the Children's Health Insurance Program (CHIP);
- Ensuring proper payment of financial assistance in the form of advanced payment of the premium tax credit (APTC) to issuers where a consumer is determined eligible;
- Operating a quality rating system for display on Exchange websites; and
- Conducting certification and oversight of SBEs.

If a State elects to use the FFE, CMS will oversee these additional functions:

- Certifying qualified health plans (QHPs) and stand-alone dental plans (SADPs) after reviewing health plan benefits and rates;
- Providing consumers the ability to apply for coverage, conducting enrollment reconciliation with issuers, conducting appeals, and assisting with APTC reconciliation; and
- Educating consumers about the Exchange, including the open enrollment period (OEP), coverage options, and providing assistance to consumers.

Enhanced direct enrollment (EDE) is a new pathway for consumers to enroll in health insurance coverage through the Federal Exchange. This pathway allows CMS to partner with the private sector to provide a more user-friendly and seamless enrollment experience for consumers by allowing them to apply for and enroll in an Exchange plan directly through an approved issuer or web-broker without the need to be redirected to Healthcare.gov or contact the consumer call center. In FY 2021, CMS will support further innovations for consumers to purchase QHPs outside of Healthcare.gov by continuing to work with issuers to build a streamlined and simplified enrollment process where consumers can sign up for health plans offered on the Exchanges through direct enrollment partners, including agents and brokers.

Funding History

Fiscal Year	Program Level
FY 2017	$2,075,714,000
FY 2018	$1,948,818,000
FY 2019	$1,655,367,000
FY 2020 Enacted	$1,784,855,000
FY 2021 President's Budget	$1,197,112,000

*NOTE: The FY 2019 Final and 2020 Enacted levels are estimates as of January 2020.

Budget Request

The FY 2021 Budget request for Federal Exchange activities is $1,197.1 million at the program level, of which $1,171.7 million is proposed to be funded from user fees and $25.4 million from the discretionary Health Care Fraud and Abuse Control (HCFAC) appropriation.

- *Health Plan Bid Review, Management, and Oversight:* $18.3 million. CMS oversees the annual certification process for QHPs and SADPs offered on the individual and small group markets. CMS supports the process by developing operational guidance, creating tools, and providing technical assistance to issuers on certification requirements and certifies agents and brokers to participate in the Federal Exchanges.

- *Payment and Financial Management:* $42.2 million. States and issuers supply a range of enrollment, premium, and claims data for calculating financial payments across multiple Exchange activities using the Health Insurance Oversight System (HIOS). Exchange-related payments leverage CMS' Healthcare Integrated General Ledger Accounting System and financial management processes such as reporting and debt management.

  Each month, CMS receives enrollment information from issuers and Exchanges and then calculates and pays the amount of APTC owed to issuers. APTC is reconciled by the IRS when the consumer files a tax return.

  The Risk Adjustment program balances the risk pool of compliant plans in the individual and small group markets by transferring premium revenue from plans with below-average actuarial risk to plans with above-average actuarial risk within a market within a state. The Risk Adjustment Data Validation (RADV) program conducts reviews and audits of data that was used to calculate risk adjustment transfers. This funding supports the RADV program, through which CMS is working to strengthen financial oversight, by improving the accuracy and scope of these RADV medical records-based reviews.

- *Eligibility and Enrollment:* $292.8 million. This activity allows consumers to submit applications for health coverage during the open enrollment period or special enrollment periods (SEPs). Electronic applications are processed through HealthCare.gov where eligibility for financial assistance, Medicaid, and CHIP are verified through the Data Services Hub.

When consumer-provided information does not match electronic data sources, data match inconsistencies are generated. CMS reviews consumer-submitted supporting documentation to resolve the issue while consumers have the opportunity to appeal determinations for financial assistance and SEP eligibility. Appeal activities include processing incoming documents, reviewing appeal requests and supporting documentation, requesting information and documents from appellants, and general case management.

CMS works with issuers to reconcile enrollment, resolving discrepancies identified through analytics or by issuers themselves. This process ensures only consumers who pay their monthly premium remain enrolled in coverage and that issuers receive the appropriate amount of financial assistance payments.

- *Consumer Information and Outreach:* $306.6 million. CMS ensures consumers are fully supported not only during open enrollment, but throughout the plan year using mail, phone, and Healthcare.gov. The consumer call center is the primary means for consumers to ask questions, get help with online tools, complete an application, and report life event changes and inconsistencies. The call center offers support in over 200 languages and is open 24 hours a day, 7 days a week. The current estimated call volume for FY 2021 is 17.4 million calls.

  Through the Government Printing Office, CMS prints and mails pertinent consumer notices and provides educational publications on a wide variety of topics. Year-round on the ground community-based support is available through Navigators that supply impartial information to consumers on eligibility applications and selecting a plan.

- *Information Technology (IT):* $430.8 million. The Exchange IT environment uses a cloud-based approach to support consumer facing websites, issuer facing electronic data exchanges, and back end systems. The IT infrastructure is designed to support peak volumes, while ensuring a smooth user experience. New technical architecture and software code is integrated into existing production environments using a comprehensive end-to-end testing methodology that ensures existing performance levels are maintained or improved. CMS administers a comprehensive IT security program that is designed to prevent and detect intrusions into the environments. The Exchanges also leverage existing CMS Enterprise Shared Services. Major applications that support Exchanges include:

  - *Data Services Hub* – Provides a query-based verification service for information supplied by the consumer during the application process with Federal entities and private data sources. Verified data includes citizenship or immigration status, income, household size, and eligibility for Medicare, veteran's benefits, or federal employee benefits.

  - *Health Insurance Oversight System (HIOS)* – Serves as the primary data collection system for issuer oversight and plan information. The system collects issuer data on claims for risk adjustment, rate review justifications, and medical loss ratio reporting for oversight activities.

  - *Federal Health Care Exchanges (HIX)* – Provides the back end functionality of the Federal Exchanges including plan management, eligibility, and enrollment.

- *HealthCare.gov Web Portal* – Allows consumers to search and compare health insurance plans, enroll in coverage, receive financial assistance determinations, upload documents, and submit appeals.

- *Small Business Health Option Program (SHOP):* $0.2 million. SHOPs provide small businesses, defined as those with fewer than 50 employees, with options for providing health insurance to their employees. CMS intends to continue to fund the operation of a toll-free telephone hotline to respond to requests for assistance related to the SHOP program in FY 2021.

- *Exchange Quality:* $9.7 million. CMS provides quality rating information using a five star rating scale based on clinical quality measures and an enrollee satisfaction survey to give consumers easy to compare quality metrics on QHPs. During the 2020 Open Enrollment period, for the first time quality ratings were available nationwide across Exchanges and displayed on HealthCare.gov. Each year, an overall quality rating and additional ratings for the three categories (Medical Care, Member Experience, Plan Administration) which comprise the overall rating will be displayed during open enrollment to increase transparency and empower consumers to make informed healthcare decisions for themselves and their families.

- *Program Integrity:* $25.4 million. In coordination with efforts funded by the Health Care Fraud and Abuse Control account, this section includes work necessary to ensure program integrity in the Exchanges. CMS is developing a methodology to measure and report estimated improper payments for APTC and will continue to strengthen oversight of State Exchange operations. CMS will also continue to operate a consumer complaint call center and to investigate complaints and to conduct investigations and data analytics using the FFE and other data sources. CMS operates focused fraud prevention efforts in areas that have high risk factors for enrollment fraud and provides oversight for agents and brokers to ensure they are in good standing with the state. In FY 2020, CMS invested funding to begin implementing an improper Payment Assessment, which explains the decreased request in FY 2021.

- *Planning and Performance:* $21.1 million. CMS supports general planning and oversight of Exchange activities to ensure integration and coordination across CMS, with issuers, and federal partners.

- *Administration:* $50.0 million. This funding supports staffing and administration for the Federal Exchange. The FY 2021 request supports staffing and administration consistent with the FY 2020 request level.

Proposed Legislation

CMS is proposing to allow user fees collected for FFE operations to be available for any federal administrative Exchange-related operating activity – see General Provision below. Currently, activities that CMS conducts on behalf of all Exchanges are not eligible to be funded by user fees. These activities consist of enrollment eligibility verification, issuer payment activities, quality work, and associated IT, including the Health Insurance Data Services Hub. This proposal would allow activities such as these to be paid from collected user fees.

General Provision:

SEC. XXX. Any assessment or user fee charged pursuant to section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act credited to the "Centers for Medicare and Medicaid Services—Program Management" account shall be available for any other Federal administrative expenses the Secretary incurs for activities related to the Exchange program, in addition to any other purposes authorized by law and shall remain available until expended for the purposes described in this section.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of National Drug Control Policy

(Dollars in Millions except where indicated otherwise)

Resource Summary	FY 2019 Estimates	FY 2020 Estimates	FY 2021 Estimates
Drug Resources by Decision Unit and Function			
Medicaid Treatment	$5,480	$5,640	$5,880
Total Decision Unit #1 Medicaid	**$5,480**	**$5,640**	**$5,880**
Medicare Treatment	$2,680	$2,910	$3,140
Total Decision Unit #2 Medicare	**$2,680**	**$2,910**	**$3,140**
Total Funding	**$8,160**	**$8,550**	**$9,020**
Drug Resources Personnel Summary			
Total FTEs (direct only)	--	--	--
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)[1]	$1,167.9	$1,260.5	$1,335.7
Drug Resources Percentage	0.7%	0.7%	0.7%

Program Summary

Mission

As an effective steward of public funds, the Centers for Medicare & Medicaid Services (CMS) is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at a lower cost. Through its coverage of drug treatment services included within Medicare and Medicaid benefit payments, CMS helps support the goals of the Office of National Drug Control Policy (ONDCP) by providing substance use disorder treatment to eligible beneficiaries.

[1] The total agency budget reflects only Medicare and Medicaid current law benefit costs as estimated by the CMS Office of the Actuary. The Medicaid total reflects the net outlays of Medical Assistance Payments benefit grants and the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention. The Medicare total reflects gross benefit outlays.

Methodology

Medicaid
These projections were based on data from the Medicaid Analytic eXtract (MAX) for 2007 through 2012, based on expenditures for claims with substance use disorders as a primary diagnosis. Managed care expenditures were estimated based on the ratio of substance use disorder expenditures to all expenditures for fee-for-service by eligibility group. The estimates were trended forward to Fiscal Year (FY) 2018 using the growth rate of expenditures by state and eligibility category from the CMS-64, MAX data, and estimates consistent with the President's Budget. The annual growth rates were adjusted by comparing the rate of substance use disorder expenditure growth from 2007-2011 to all service expenditure growth and adjusting the growth rate proportionately.

Medicare
The estimates of Medicare spending for the treatment of substance use disorder are based on the FY 2021 President's Budget baseline. These projections reflect estimated Part A and Part B spending and are based on an analysis of historical fee-for-service claims through 2018, using the primary diagnosis code[2] included on the claims. The historical trend was used to make projections into the future. These projections are very similar to those for the 2020 President's Budget and vary only slightly due to changes in the baseline.

An adjustment was made to reflect spending for beneficiaries who are enrolled in Medicare Advantage plans, since their actual claims are not available. It was assumed that the proportion in costs related to substance use disorder treatment was similar for beneficiaries enrolled in Medicare Advantage plans as for those enrolled in fee-for-service Medicare.

These estimates do not include spending under Medicare Part D because there is not a straightforward way to get this information. There is no diagnosis code associated with prescription drug claims, and drugs used to treat substance use disorder are often also used to treat other conditions.

Budget Summary

The total FY 2021 drug control outlay estimate for CMS is $9,020.0 million. This estimate reflects Medicaid and Medicare (excluding Part D) benefit outlays for substance use disorder treatment. Overall, year-to-year projected growth in substance use disorder spending is a function of estimated overall growth in Medicare and Medicaid spending.

Medicaid
FY 2021 outlay estimate: $5,880.0 million
(Reflects $240.0 million increase from FY 2020)

Medicaid is a means-tested health care entitlement program financed by states and the federal government. Medicaid mandatory services include substance use disorder services for detoxification and treatment for substance use disorder needs identified as part of early

[2] Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for substance abuse include a subset of the 291, 292, 303, 304, and 305 category of codes, and also ICD-9 code 7903. The applicable ICD-10 codes for substance abuse include a subset of the F10, F11, F12, F13, F14, F15, F16, F17, F18, and F19, and R78 ICD-10 category of codes.

and periodic screening, and diagnostic and treatment services for individuals under 21 years of age. Additional Medicaid substance use disorder treatment services may be provided as optional services. The *Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act* also requires states to cover medication-assisted treatment (MAT) from FY 2020 – FY 2025.

Medicare
FY 2021 outlay estimate: $3,140.0 million
(Reflects $230.0 million increase from FY 2020)

Medicare provides coverage of hospital, physician, skilled nursing facility, home health care, and other medical care services, as well as prescription drug coverage, to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicare substance use disorder treatment benefit payments are made by Medicare Part A and Medicare Part B. This benefit outlays total includes the estimated impact for services provided to beneficiaries enrolled in Medicare Advantage. As noted above, Medicare Part D prescription drug spending is not counted in these estimates.

Performance

Performance measures are used across the health care delivery system and across federal payers, including Medicare and Medicaid, to improve outcomes, experience of care, population health, and health care affordability. In clinical and behavioral health care, measurement has been associated with improvements in providers' use of evidence-based strategies and health outcomes. CMS uses quality measures in its various programs that include quality improvement, pay for reporting, and public reporting.

CMS has a number of mechanisms to help discourage prescribing practices that place beneficiaries at risk of harm. These practices are employed judiciously to prevent problematic providers who fail to meet Medicare requirements from harming beneficiaries. CMS has continued to monitor Medicare prescribing patterns for potential misuse or abuse.

In FY 2021, CMS will continue to implement the many Medicare and Medicaid-related provisions of the SUPPORT Act. Key provisions include: temporarily allowing states to receive federal reimbursement for services provided to individuals residing in Institutions for Mental Diseases (IMD) according to the parameters of applicable statutory and programmatic authorities, beginning in FY 2020; Medicare coverage of opioid use disorder treatment services in Opioid Treatment Programs (OTPs) through a new bundled payment for such services, beginning in Calendar Year (CY) 2020; requiring all state Medicaid programs to cover medication assisted treatment MAT for a defined period of time, beginning in FY 2021; eliminating barriers to telehealth for the provision of substance use disorder (SUD) services to Medicare beneficiaries, beginning in CY 2020; and, implementing a new Medicare demonstration that will test whether a care management fee and performance-based incentive for providers will improve outcomes for beneficiaries being treated for Opioid Use Disorder. These and other efforts have helped CMS protect its beneficiaries from the harms associated with opioid misuse, while maintaining the ability of beneficiaries with pain to access necessary treatment.

CMS updated its CMS Roadmap to Address the Opioid Crisis in March 2019, focused on three primary strategies to address this national challenge. These strategies include:

(1) Prevention - Managing pain using a safe and effective range of treatment options that rely less on prescription opioids;
(2) Treatment - Expanding access to treatment for opioid use disorders; and
(3) Data - Utilizing data to target prevention and treatment efforts and to identify fraud and abuse.

In addition, the Department of Health and Human Services (HHS) established a FY 2018-2019 HHS-wide Agency Priority Goal (APG) focused on *Reducing Opioid Morbidity and Mortality.* CMS is a supporting partner in that effort. HHS will continue this APG for FY 2020-2021. Additional information can be found on Performance.gov.

Medicaid

In FY 2020, states will continue voluntarily reporting on a core set of health care quality measures for adults and children enrolled in Medicaid and CHIP. The 2019 Adult Core Set included 12 measures focused on behavioral health; these along with 5 measures from the Child Core Set have been identified as a Behavioral Health Core Set. CMS publicly reports state-specific data in its Annual Reporting from the Adult Core Set on Medicaid.gov. A subset of the Child and Adult Core Set measure are also publicly reported in the Medicaid and CHIP Scorecard.

The SUPPORT Act made changes to the Medicaid Drug Utilization Review (DUR) program. Specifically, the law requires states to implement minimum opioid standards within their Medicaid Fee for Service (FFS) and managed care programs. Through amendments to Section 1902 of the Act, states are required to: implement "safety edits" and "claims review automated processes" to target reduction of opioid related fraud, misuse, and abuse, to include opioid refill requirements; monitor prescriptions for opioids and other drugs when prescribed concurrently; monitor antipsychotic prescriptions for children; and report on these activities on an annual basis to CMS[3]. Additionally, any Medicaid Managed Care Organizations, Prepaid Inpatient Health Plans, or Prepaid Ambulatory Health Plans that cover covered outpatient drugs are required to operate a DUR program that complies with certain rules and to submit detailed information about its DUR program activities to the state. State implementation of these strategies was required by October 1, 2019, and the Secretary was required to report this information to Congress beginning in FY 2020.

CMS allows states to utilize the section 1115 demonstration authority to receive federal matching funds for the continuum of services to treat SUD, including services provided to Medicaid enrollees residing in residential treatment facilities that meet the definition of an IMD. Ordinarily such residential treatment services are not eligible for federal Medicaid reimbursement due to the exclusion in the Medicaid statute of services provided to beneficiaries residing in an IMD. A State Medicaid Director Letter (SMDL # 17-003) issued November 1, 2017 describes this policy and a number of milestones or actions states are expected to meet to ensure Medicaid beneficiaries receive good quality of care in these residential facilities and continue to have access to community-based care. Participating states are also expected to take action to improve access to MAT, including ensuring that beneficiaries residing in IMDs have access to MAT. In addition, on November 13, 2018, CMS established a Section 1115 demonstration opportunity to improve access to treatment

[3] See Center for Medicaid and CHIP Services (CMCS) Informational Bulletin that supports states as they implement this section of the SUPPORT Act: https://www.medicaid.gov/federal-policy-guidance/downloads/cib080519-1004.pdf

for mental health disorders including treatment provided in inpatient and residential psychiatric facilities with improved attention to treatment for co-occurring SUDs in these settings. There are currently three states approved to implement a demonstration under this initiative, and CMS is working with a number of additional states to implement this type of demonstration. Participating states report on relevant Adult Core Measures as well as a number of other measures to help monitor program performance. As of November 14, 2019, 26 states[4] and the District of Columbia have been approved to implement 1115 SUD demonstrations.

In addition, the Medicaid Innovation Accelerator Program (IAP) supports states' ongoing payment and delivery system reforms through technical assistance with the end goal of improving the health and health care of Medicaid beneficiaries. IAP's SUD program area offers states a variety of technical assistance opportunities as they seek to improve care for individuals with a SUD, expand coverage for effective SUD treatment, and enhance SUD practices delivered to beneficiaries. Additional information is available here: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/index.html

Furthermore, the Center for Medicare & Medicaid Innovation supports the development and testing of innovative health care payment and service delivery models, including models that support SUD treatment. First, the Integrated Care for Kids Model is a child-centered local service delivery and state payment model aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and CHIP, especially those with or at-risk for developing significant health needs. Second, the Maternal Opioid Misuse model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with OUD through state-driven transformation of the delivery system surrounding this vulnerable population. Both models announced their first year participants in December 2019 and began implementation in January 2020.

Medicare

In 2017, Medicare's Physician Quality Reporting System transitioned to the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP). The program encourages reporting of quality measures by "eligible clinicians" by tying Medicare payments to performance in four areas: Quality, Promoting Interoperability (formerly Advancing Care Information), Improvement Activities, and Cost. The current program portfolio includes five Improvement Activities, and seven Quality measures that address opioid use. The Promoting Interoperability performance category includes two new opioid measures from the 2019 Physician Fee Schedule Final Rule, which align with the two new opioid measures finalized as part of the Promoting Interoperability Program in the FY 2019 Medicare Hospital Inpatient Prospective Payment System final rule.

Moreover, the SUPPORT Act established a new Medicare Part B benefit for OUD treatment services, including medications for MAT, furnished by OTPs. CMS is implementing this benefit beginning January 1, 2020, as required by the SUPPORT Act. In the CY 2020 Physician Fee Schedule Final Rule (PFS), CMS expanded coverage for OUD treatment services, including MAT, finalized bundled payment rates for services provided by opioid

[4] Five states were approved prior to publication of the 2017 SMDL being published; CMS has since approved 21 states and DC's 1115 SUD demonstrations.

treatment programs (OTPs), and added Healthcare Common Procedure Coding System (HCPCS) codes for bundled episodes of care for OUD treatment to the telehealth services list. The services furnished in an episode of care by an OTP for which payment is made include management, care coordination, psychotherapy and counseling as well as telehealth services, and methadone for MAT. CMS will consider coding and payment amounts that recognize different levels of patient need and different types of practice arrangements for future rulemaking, including use of MAT in the emergency department setting.

CMS continues to modify the measures, as needed, based on Office of the National Coordinator for Health Information Technology (ONC) and stakeholder feedback to promote interoperability and to reduce burden and implementation challenges. In addition, Medicare Shared Savings Program Accountable Care Organizations (ACOs) began receiving quarterly feedback in 2019 on four opioid overuse metrics including three Pharmacy Quality Alliance (PQA) metrics.

The CMS Quality Innovation Network Quality Improvement Organization Program (QIN-QIO) in the 11th Statement of Work worked with over 7,000 outpatient settings including pharmacies, nursing homes, and clinical practices, as well as with community coalitions and state-based efforts across the nation to improve safe management of opioid medications while addressing appropriate treatment of pain. The QIN-QIOs worked toward 2019 goals to achieve opioid adverse drug event reduction, all-cause readmission reduction, and all-cause hospital utilization reduction for the opioid "high-risk" Medicare FFS population. To reach these goals, QIN-QIOs implement interventions in partnership with clinicians, use data analytics to support local innovation and change, and support local efforts such as improving communication across settings and communities. CMS QIN-QIOs also established a methodology using CMS data to identify adverse events for high risk Medicare beneficiaries using opioid medications. QIN-QIOs provide aggregated reports to recruited providers and community coalitions to inform them on best practices, and to help identify areas of improvement. Overall, QIN-QIOs were able to achieve a 5% reduction in opioid adverse drug events (8,507 adverse drug events avoided) in the Medicare FFS high risk population. There were QIN-QIOs that were successful in states such as Rhode Island and New Hampshire, which exceeded targets for all-cause readmission and hospital utilization reduction, but overall these rates continue to be high across the nation. In the 12th Statement of Work, CMS quality improvement contractors will continue to work on improving opioid management and safety, with an overall goal of decreasing opioid related adverse events, including deaths, in the Medicare population by seven percent. Additional information about these initiatives can be found at the following links:
http://qioprogram.org/campaign-meds-management
http://qioprogram.org/qionews/topics/adverse-drug-events

CMS continues to update its interactive online Medicare Part D Opioid Drug Mapping Tool, including most recently with CY 2017 data. This tool allows the public to search de-identified Medicare Part D opioid prescription claims data at the state, county, and ZIP code levels. The tool allows users to see both the number and percentage of opioid claims at the local level, and includes extended-release opioid prescribing rates and county-level hot spots. This tool allows a better understanding of variability in provider prescribing behaviors within and across regions, and helps users to understand how this critical issue impacts communities nationwide.

Medicare Part D

In Medicare Part D, policies that enhance Part D Plan issuers' ability to address prescription opioid overutilization include: (1) drug management programs (DMPs) to better coordinate care when chronic, high-risk opioid use is present, (2) improved opioid safety alerts for pharmacists when opioid prescriptions are dispensed at the pharmacy, and (3) revised opioid quality metrics to guide performance improvement.

In April 2018, as required by the Comprehensive Addiction and Recovery Act (CARA) of 2016, CMS finalized the framework under which Part D plan sponsors could adopt DMPs beginning with plan year 2019. Under these programs, after case management and written notice, Part D plan sponsors can limit certain beneficiaries' access to coverage of opioids and/or benzodiazepines, if those beneficiaries were identified as "potential at-risk beneficiaries" under specific criteria. The criteria are based on prior opioid use and also take into account the use of multiple opioid prescribers/pharmacies. To ensure care coordination, at-risk beneficiaries may only receive their opioid and/or benzodiazepine medications from a specific prescriber or pharmacy, which the beneficiary may generally select, or the amount of opioids that is covered for them may be controlled through a beneficiary-specific point of sale claim edit for their safety.

Several provisions of the SUPPORT Act gave CMS additional authorities to strengthen Part D DMPs. These include Section 2006, which requires that Part D enrollees with a history of opioid-related overdose be included as potential at-risk beneficiaries for Part D DMPs beginning on or after January 1, 2021. Section 6064 requires Part D sponsors to also target at-risk beneficiaries in their DMPs for their Medication Therapy Management (MTM) programs. Finally, Section 2004 of the SUPPORT Act requires all Part D sponsors to have a DMP for plan years beginning on or after January 1, 2022.

In addition to DMPs, in CY 2019, CMS introduced new point of sale opioid safety alerts for Part D plan sponsors to help prevent unsafe opioid use. Safety alerts make a pharmacist aware of possible opioid overutilization at the point of sale. In real-time, these alerts can flag for a pharmacist that they should conduct additional review and/or consultation with the plan sponsor or prescriber to ensure that a prescription is appropriate. Beneficiaries who are residents of a long-term care facility, in hospice care, receiving palliative or end-of-life care, or being treated for active cancer-related pain are generally excluded from the opioid safety alerts and DMPs. Beginning in CY 2020, beneficiaries with sickle cell disease are also excluded from the opioid safety alerts.

The CY 2020 Final Call Letter supports the continuation of Part D opioid overutilization policies implemented in 2019 and CMS's continued work with providers, pharmacies, and beneficiaries to carry out these strategies. CMS also announced in the Call Letter an intention to gain experience with the new policies and closely monitor the impact on Medicare Part D prescription opioid overuse to evaluate the need for potential modifications or development of alternative or additional approaches in the future. In an effort to improve access to opioid-reversal agents, the Call Letter encouraged plans to include at least one naloxone product on a generic or Select Care Tier and recommended co-prescribing of naloxone with opioid prescriptions to beneficiaries who are at an increased risk for opioid overdose.

CMS is currently at work on implementing other provisions of the SUPPORT Act that have a direct bearing on overall drug utilization, such as the identification of and notification to

outlier opioid prescribers on an annual basis; the establishment of guidelines for Part D plan sponsors to report pharmacy payment suspensions based on credible allegations of fraud; and the creation of a secure portal for plan sponsors and CMS to exchange information on suspicious and substantiated activities related to opioid prescribing.

CMS also uses quality measures developed by the PQA to track overall trends in opioid overuse across the Medicare Part D program. Effective January 1, 2020, the Medicare Part D program implemented three PQA metrics which measure the use of opioids from multiple providers and/or at high dosage (i.e., 90 morphine milligram equivalents [MME]) in persons without cancer and the PQA Concurrent Use of Opioids and Benzodiazepines measure. Using these quality metrics, CMS will better track trends in opioid misuse and abuse across the Medicare Part D program and between plan sponsors.

Clinical Quality Measure Reporting

CMS has included opioid use disorders as a meaningful measure area in the Meaningful Measures framework and also incorporated opioid-related measures and clinical improvement activities for clinicians to select as they participate in Medicare's QPP. For the QPP, the definition of high priority measures includes opioid-related measures. CMS is also working in partnership with ONC to incorporate clinical quality measures (CQMs) into electronic health records to assist in implementing healthcare delivery and payment. CMS included several opioid-related quality measures in the 2019 "Measures Under Consideration (MUC) List," which is a list published each year to inform the public about measures being considered for use in Medicare's quality reporting programs. The "Safe Use of Opioids—Concurrent Prescribing" electronic clinical quality measure (electronic CQM) was finalized in the Inpatient Prospective Payment System final rule published on August 16, 2019 for use in the Hospital Inpatient Quality Reporting Program and the Promoting Interoperability Program for eligible hospitals and critical access hospitals. In addition, a few Qualified Clinical Data Registries have developed opioid-related measures that MIPS eligible clinicians can report when they submit their quality data to CMS. The 2019 MUC list included "Use of Opioids from Multiple Providers in Persons Without Cancer," "Use of Opioids at High Dosage in Persons Without Cancer" and "Use of Opioids from Multiple Providers at a High Dosage in Persons Without Cancer," which will be reviewed by the Measure Applications Partnership, a multi-stakeholder committee convened under the National Quality Forum (NQF), for use in the Medicare Part C and D Star Ratings. CMS continues to consider additional opioid related measures for use in the Medicare quality programs through its annual rulemaking processes.

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Object Classification - Direct Budget Authority
CMS Program Management
(Dollars in Thousands)

Object Class	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Direct Budget Authority			
Personnel compensation:			
Full-time permanent (11.1)	$ 484,361	$ 481,835	$ 504,514
Other than full-time permanent (11.3)	$ 11,124	$ 13,911	$ 11,385
Other personnel compensation (11.5)	$ 7,806	$ 8,850	$ 8,850
Military personnel (11.7)	$ 14,930	$ 15,821	$ 15,570
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 518,221**	**$ 520,417**	**$ 540,319**
Civilian benefits (12.1)	$ 152,938	$ 156,398	$ 159,627
Military benefits (12.2)	$ 7,691	$ 7,810	$ 8,021
Benefits to former personnel (13.0)	$ -	$ -	$ -
Subtotal Pay Costs	**$ 678,850**	**$ 684,625**	**$ 707,967**
Travel and transportation of persons (21.0)	$ 5,464	$ 3,224	$ 5,464
Transportation of things (22.0)	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ 5,100	$ 5,100	$ 5,100
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 2,453	$ 2,456	$ 2,453
Other Contractual Services:			
Advisory and assistance services (25.1)	$ -	$ -	$ -
Other services (25.2)	$ 2,014,517	$ 2,009,878	$ 1,683,866
Purchase of goods and services from government accounts (25.3)	$ 2,778	$ 2,778	$ 2,883
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ 16,654
Medical care (25.6)	$ 1,235,611	$ 1,245,660	$ 1,268,192
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,272,960**	**$ 3,278,370**	**$ 2,971,595**
Supplies and materials (26.0)	$ 969	$ 969	$ 969
Equipment (31.0)	$ -	$ -	$ -
Land and Structures (32.0)	$ -	$ -	$ -
Investments and Loans (33.0)	$ -	$ -	$ -
Grants, subsidies, and contributions (41.0)	$ -	$ -	$ -
Interest and dividends (43.0)	$ -	$ -	$ -
Refunds (44.0)	$ -	$ -	$ -
Subtotal Non-Pay Costs	**$ 3,286,946**	**$ 3,290,119**	**$ 2,985,581**
Total Direct Budget Authority /1	**$ 3,965,796**	**$ 3,974,744**	**$ 3,693,548**
Average Cost per FTE			
Civilian FTEs	4,226	4,088	4,152
Civilian Average Salary	$ 153	$ 160	$ 163
Percent change	0%	4%	2%
Military FTEs	134	134	134
Military Average Salary	$ 169	$ 176	$ 176
Percent change	0%	4%	0%
Total OPDIV FTEs	4,360	4,222	4,286
Total OPDIV Average Salary	$ 156	$ 162	$ 165
Percent change	0%	4%	2%

/1 FY 2019 reflects the use of HHS Secretary's Transfer Authority totaling $8.948 million.

CMS Program Management
Salaries and Expenses
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$ 484,361	$ 481,835	$ 504,515
Other than full-time permanent (11.3)	$ 11,124	$ 13,911	$ 11,384
Other personnel compensation (11.5)	$ 7,806	$ 8,850	$ 8,850
Military personnel (11.7)	$ 14,930	$ 15,821	$ 15,570
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 518,221**	**$ 520,417**	**$ 540,319**
Civilian benefits (12.1)	$ 152,938	$ 156,398	$ 159,627
Military benefits (12.2)	$ 7,691	$ 7,810	$ 8,021
Benefits to former personnel (13.0)	$ -	$ -	$ -
Total Pay Costs	**$ 678,850**	**$ 684,625**	**$ 707,967**
Travel and transportation of persons (21.0)	$ 5,464	$ 3,224	$ 5,464
Transportation of things (22.0)	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ 5,100	$ 5,100	$ 5,100
Rental payments to Others (23.2)	$ -	$ -	$ -
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 2,453	$ 2,456	$ 2,453
Other Contractual Services:			
Advisory and assistance services (25.1)	$ -	$ -	$ -
Other services (25.2)	$ 2,014,517	$ 2,009,878	$ 1,683,866
Purchase of goods and services from government accounts (25.3)	$ 2,778	$ 2,778	$ 2,883
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 20,054	$ 16,654
Medical care (25.6)	$ 1,235,611	$ 1,245,660	$ 1,268,192
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,272,960**	**$ 3,278,370**	**$ 2,971,595**
Supplies and materials (26.0)	$ 969	$ 969	$ 969
Total Non-Pay Costs	**$ 3,286,946**	**$ 3,290,119**	**$ 2,985,581**
Total Salary and Expense /1	**$ 3,965,796**	**$ 3,974,744**	**$ 3,693,548**
Direct FTE	4,360	4,222	4,286

/1 FY 2019 reflects the use of HHS Secretary's Transfer Authority totaling $8.948 million.

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2019 Actual Total	2020 Est. Total	2021 Est. Total
Office of the Administrator			
Direct FTEs	43	44	46
Reimbursable FTEs	0	0	0
Subtotal	43	44	46
Center for Clinical Standards and Quality			
Direct FTEs	186	194	186
Reimbursable FTEs	41	40	40
Subtotal	227	234	226
Center for Consumer Information and Insurance Oversight			
Direct FTEs	224	220	220
Reimbursable FTEs	165	182	182
Subtotal	389	402	402
Center for Medicaid and CHIP Services			
Direct FTEs	542	523	533
Reimbursable FTEs	0	0	0
Subtotal	542	523	533
Center for Medicare			
Direct FTEs	646	636	635
Reimbursable FTEs	6	6	6
Subtotal	652	642	641
Center for Medicare and Medicaid Innovation			
Direct FTEs	0	0	0
Reimbursable FTEs	0	0	0
Subtotal	0	0	0
Center for Program Integrity			
Direct FTEs	0	0	0
Reimbursable FTEs	30	31	31
Subtotal	30	31	31
Office of Acquisition & Grants Management			
Direct FTEs	154	146	151
Reimbursable FTEs	2	2	2
Subtotal	156	148	153
Office of the Actuary			
Direct FTEs	81	78	80
Reimbursable FTEs	0	0	0
Subtotal	81	78	80
Office of Communications			
Direct FTEs	218	211	214
Reimbursable FTEs	1	1	1
Subtotal	219	212	215
Office of Information Technology			
Direct FTEs	400	388	394
Reimbursable FTEs	4	5	5
Subtotal	404	393	399
Office of Equal Opportunity and Civil Rights			
Direct FTEs	30	29	29
Reimbursable FTEs	0	0	0
Subtotal	30	29	29
Federal Coordinated Health Care Office			
Direct FTEs	29	28	28
Reimbursable FTEs	0	0	0
Subtotal	29	28	28

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2019 Actual Total	2020 Est. Total	2021 Est. Total
Office of Financial Management			
Direct FTEs	226	219	222
Reimbursable FTEs	8	8	8
Subtotal	234	227	230
Office of Hearings and Inquiries			
Direct FTEs	122	117	119
Reimbursable FTEs	0	0	0
Subtotal	122	117	119
Office of Legislation			
Direct FTEs	55	53	54
Reimbursable FTEs	0	0	0
Subtotal	55	53	54
Continuous Improvement and Strategic Planning			
Direct FTEs	10	9	10
Reimbursable FTEs	0	0	0
Subtotal	10	9	10
Digital Service at CMS			
Direct FTEs	7	7	7
Reimbursable FTEs	0	0	0
Subtotal	7	7	7
Office of Minority Health			
Direct FTEs	18	21	18
Reimbursable FTEs	0	0	0
Subtotal	18	21	18
Office of Human Capital			
Direct FTEs	181	180	177
Reimbursable FTEs	0	0	0
Subtotal	181	180	177
Office of Support Services and Operations			
Direct FTEs	92	89	91
Reimbursable FTEs	1	1	1
Subtotal	93	90	92
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	148	142	145
Reimbursable FTEs	0	4	4
Subtotal	148	146	149
Office of Enterprise Data and Analytics			
Direct FTEs	65	67	64
Reimbursable FTEs	0	0	0
Subtotal	65	67	64
Health Informatics Office (HIO)			
Direct FTEs	4	4	4
Reimbursable FTEs	0	0	0
Subtotal	4	4	4
Consortia			
Direct FTEs	880	819	858
Reimbursable FTEs	15	29	29
Subtotal	895	848	887
Total, CMS Program Management FTE 1/ 2/	**4,633**	**4,531**	**4,595**
Total, CMS Military Staffing - Disc. (Non-Add) 2/	*134*	*134*	*134*
Total, CMS Military Staffing - Reimbursable (Non-Add) 2/	*16*	*16*	*16*

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2019 Actual Total	2020 Est. Total	2021 Est. Total
American Recovery and Reinvestment Act (ARRA)	*63*	*46*	*46*
CMS Military Staffing - Direct	*0*	*0*	*0*
ACA Directly Appropriated	*11*	*15*	*15*
CMS Military Staffing - Direct	*1*	*1*	*1*
PAMA/IMPACT/MACRA	*67*	*55*	*3*
CMS Military Staffing - Direct	*9*	*9*	*9*
Total, CMS Program Management FTE	***151***	***126***	***74***

1/ FY 2019 reflects actual FTE consumption. This will be adjusted for OneCMS.

2/ Includes FTEs funded from Program Management Federal Administration and Reimbursables only.

Average GS Grade

FY 2017	**13.4**
FY 2018	**13.4**
FY 2019	**13.4**
FY 2020	**13.4**
FY 2021	**13.4**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	FY 2019 Final	FY 2020 Enacted	FY 2021 President's Budget
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$168	$172	$175
Subtotal	70	70	70
Total - ES Salaries	$13,134	$13,434	$13,612
GS-15	566	547	556
GS-14	561	542	551
GS-13	2,001	1,935	1,966
GS-12	596	576	585
GS-11	98	95	96
GS-10	1	1	1
GS-9	129	124	126
GS-8	1	1	1
GS-7	44	43	43
GS-6	45	43	44
GS-5	61	59	60
GS-4	43	42	43
GS-3	9	9	9
GS-2	0	0	0
GS-1	0	0	0
Subtotal 1/	4,154	4,017	4,081
Total - GS Salary 1/	$482,183	$483,030	$502,428
Average GS grade 1/	13.4	13.4	13.4
Average GS salary 1/	$116.077	$120.247	$123.114

1/ Reflects direct discretionary staffing within the Program Management account.

CMS Program Management
Programs Proposed for Elimination

CMS has no programs proposed for elimination within the Program Management account.

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2010			FY 2011			FY 2012		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002	$ 30,000	0			2			0	
Rate Review Grants	1003	$ 250,000	0			0			0	
Pre-existing Condition Insurance Plan Program	1101	$ 5,000,000	0			13			18	
Reinsurance for Early Retirees	1102	$ 5,000,000	0			2			4	
Affordable Choices of Health Benefit Plans	1311	$ 49,322	0		$ 478,374	28		$ 1,654,596	44	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322	$ 6,000,000	0		$ (2,200,000)	1		$ (400,000)	6	
CO-OP Contingency Fund	1322/644		0			0			0	
Adult Health Quality Measures 2/	2701	$ 60,000	0		$ 60,000	2		$ 60,000	5	
Medicaid Emergency Psychiatric Demonstration	2707		0		$ 75,000	0				
Quality Measurement 2/	3014	$ 20,000	0		$ 20,000	2		$ 20,000	4	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021	$ 5,000	4		$ 10,000,000	68			163	
Independence At Home Demonstration 2/	3024	$ 5,000	0		$ 5,000	0		$ 5,000	3	
Community Based Care Transitions	3026		0		$ 500,000	0			2	
Treatment of Certain Complex Diagnostic Lab Tests	3113	$ 5,000	0			0			2	
Medicaid Incentives for Prevention of Chronic Disease	4108		0		$ 100,000	0			1	
Community Prevention and Wellness	4202	$ 50,000	0			0			1	
Graduate Nurse Education 2/	5509		0			0		$ 50,000	1	
Sunshine Act	6002		0			0			0	
Long Term Care (LTC) National Background Checks	6201	$ 160,000	3			2			3	
Provider Screening & Other Enrollment Requirements 1/	6401		0			5			8	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0		$ 10,000	2		$ 10,000	2	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			2			2	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	Such Sums	0		Such Sums	0		$ 302,000	2	
Total ACA Direct Appropriated FTEs			**7**			**129**			**271**	

1/ From FY 2014 through FY 2018, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), and FY 2020 (-5.9%).

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2013			FY 2014			FY 2015		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		12			7			5	
Reinsurance for Early Retirees	1102		11			4			4	
Affordable Choices of Health Benefit Plans	1311	$ 2,147,000	56		$ 784,000	51		$ 469,624	49	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322	$ (2,278,544)	18			15			0	
CO-OP Contingency Fund	1322/644	$ 240,259							15	
Adult Health Quality Measures 2/	2701	$ 56,940	10		$ 55,680	9			11	
Medicaid Emergency Psychiatric Demonstration	2707					0			1	
Quality Measurement 2/	3014	$ 18,980	6		$ 18,560	9			9	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		258			355			479	
Independence At Home Demonstration 2/	3024	$ 4,745	2		$ 4,640	1		$ 4,635	1	
Community Based Care Transitions	3026		1			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		1			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		1			1			1	
Community Prevention and Wellness	4202		1			0			0	
Graduate Nurse Education 2/	5509	$ 47,450	0		$ 46,400	0		$ 46,350	1	
Sunshine Act	6002	$ 16,050	11		$ 1,024	14		$ 21,399	16	
LTC National Background Checks	6201		4			5			5	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 5,000	10			12		$ 18,035	13	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 13,000	1		$ 3,000	1		$ 27,377	2	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 3,300	1		$ 3,783	2		$ 3,975	2	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$ 418	1		$ 316	1		$ 549	1	
Total ACA Direct Appropriated FTEs			**405**			**487**			**615**	

1/ From FY 2014 through FY 2018, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), and FY 2020 (-5.9%).

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2016			FY 2017			FY 2018		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003								0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0	
Reinsurance for Early Retirees	1102		0			0			0	
Affordable Choices of Health Benefit Plans	1311	$ 20,163	34		$ 18,221	25		$ 12,655	24	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
CO-OP Contingency Fund	1322/644		18			0			0	
Adult Health Quality Measures 2/	2701		11			8			6	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0	
Quality Measurement 2/	3014		0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		521			551			540	
Independence At Home Demonstration 2/	3024		1			1			1	
Community Based Care Transitions	3026		1			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education 2/	5509		1			2			2	
Sunshine Act	6002	$ 4,211	17		$ 5,615	22			0	
LTC National Background Checks	6201		6			6			4	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 3,509	14		$ 3,509	9			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 468	2		$ 468	1			0	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 468	2			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323	$329	1			0			0	
Total ACA Direct Appropriated FTEs			**629**			**625**			**577**	

1/ From FY 2014 through FY 2018, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), and FY 2020 (-5.9%).

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2019			FY 2020			FY 2021		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
ACA Direct Appropriated										
Health Insurance Consumer Information	1002		0			0			0	
Rate Review Grants	1003		0			0			0	
Pre-existing Condition Insurance Plan Program	1101		0			0			0	
Reinsurance for Early Retirees	1102		0			0			0	
Affordable Choices of Health Benefit Plans	1311		0			0			0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers Consumer Operated and Oriented Plan (CO-OP) Program	1322		0			0			0	
CO-OP Contingency Fund	1322/644		0			0			0	
Adult Health Quality Measures 2/	2701	$ 1,200	8		$ 1,200	10		$ 1,200	10	
Medicaid Emergency Psychiatric Demonstration	2707		0			0			0	
Quality Measurement 2/	3014		0			0			0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021	$ 92,000	533		$ 91,500	574		$ 91,500	574	
Independence At Home Demonstration 2/	3024		0			0			0	
Community Based Care Transitions	3026		0			0			0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0			0			0	
Medicaid Incentives for Prevention of Chronic Disease	`		0			0			0	
Community Prevention and Wellness	4202		0			0			0	
Graduate Nurse Education 2/	5509		0			0			0	
Sunshine Act	6002		0			0			0	
LTC National Background Checks	6201	$ 857	4		$ 857	6		$ 857	6	
Provider Screening & Other Enrollment Requirements 1/	6401		0			0			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0			0			0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0			0			0	
Termination of Provider Participation under Medicaid 1/	6501		0			0			0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323		0			0			0	
Total ACA Direct Appropriated FTEs			**545**			**590**			**590**	

1/ From FY 2014 through FY 2018, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), FY 2017 (-6.9%), FY 2018 (-6.6%), FY 2019 (-6.2%), and FY 2020 (-5.9%).

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

DHHS: Centers for Medicare and Medicaid Services (CMS)

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*
In order to attract and retain highly skilled and qualified physicians, CMS uses two special pay systems, Physician's Comparability Allowance (PCA) and the Physician's and Dental Pay (PDP). Details of the PDP are not included in this report. The majority of CMS physicians receive PCA. CMS physicians are recruited nationwide to support the work of Medicare and Medicaid Programs. CMS has a continual need to access highly skilled physicians to carry out the unique mission of the agency. The biggest challenge is that even with the PCA, CMS is unable to match physician salary in the private sector. Generally speaking, physicians tend to accept more private sector opportunities due to the restrictions of the GS pay scale.

3 and 4) Please complete the table below with details of the PCA agreement for the following years:

	FY 2019 (Final)	**FY 2020 ** (Estimates)**	**FY 2021 President's Budget (Estimates)**
3a) Number of Physicians Receiving PCAs*	37	45	50
3b) Number of Physicians with One-Year PCA Agreements	5	4	4
3c) Number of Physicians with Multi-Year PCA Agreements	32	41	46
4a) Average Annual PCA Physician Pay (without PCA payment)	$162,913	$162,913	$162,913
4b) Average Annual PCA Payment	$25,737	$25,737	$25,737

* All Physicians are in Category IV-B Health and Medical Admin as additional physician categories have not been designated by CMS.

** FY 2020 data will be approved during the FY 2021 Budget cycle.

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

(*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*
Recent legislation over the past several years required CMS to implement new programs. Some of these mandates require establishing additional new physician positions or quickly filling vacated physician positions to fill very specific needs. Many of these positions were also supervisory positions. Even though CMS has experienced many hurdles trying to recruit physicians, the PCA is still necessary because the candidates with quality experience make significantly more money in the private sector compared to what CMS would be able to offer them without PCA. PCA has made the salary offers more comparable to give us the opportunity to attract and hire exceptional physicians. Without this recruitment and retention allowance, CMS would not be able to attract and retain highly qualified physicians.

6) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

The average annual PCA physician pay (without PCA payment) will increase in FY 2020 resultant of 11 physicians being eligible for step increases during that timeframe. The average annual PCA amounts will increase in FY 2021 as four physicians will have completed their 24 months as a government physician. Once they have more than 24 months, the maximum PCA limit for one year service agreements is $19,000 and for multi-year agreements is $30,000. Currently, of the 37 physicians, CMS has 18 physicians receiving the maximum PCA amount.

In the last month of FY 2018, CMS had another three physicians leave. CMS continues to experience a decrease in our physician positions. During FY 2019 five physicians left the CMS PCA program (two retired, one resigned, one transferred to another agency, and one was reassigned to a Title 38 position). With five physicians leaving in FY 2019, only four new physicians were hired.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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SIGNIFICANT ITEMS AND REPORTS TO CONGRESS FOR INCLUSION IN THE FY 2021 CONGRESSIONAL JUSTIFICATION

Air Ambulance Costs - The agreement requests CMS report to the Committees no later than one year after enactment of this Act on any evidence of air ambulance base closures in rural areas which may have affected patients' access to care, and to consider relevant factors that have affected air ambulance transportation costs when setting appropriate air ambulance payments, and consider whether costs currently align with payments.

Action Taken or To Be Taken

CMS agrees it is essential that Medicare beneficiaries have adequate access to ambulance services, especially in rural areas. The regulation of air ambulances spans multiple federal agencies, and CMS notes that section 418 of the FAA Reauthorization Act of 2018 (Pub. L. 115-254) requires the Secretary of Transportation, in consultation with the Secretary of HHS, to establish an advisory committee that includes Department of Transportation, HHS, and others, to review options to improve the disclosure of charges and fees for air medical services, better inform consumers of insurance options for those services, and better inform and protect consumers of these services.

Section 1834(l) (17) of the Social Security Act, which addresses data collection, applies only to providers and suppliers of ground ambulance services. Therefore, CMS does not have the data necessary to provide information specific to air ambulance company costs.

Alternatives to Cardiac Stress Test - The Committee is aware of the significant health and cost savings advantages of new technology for non-invasive diagnosis of coronary arterial disease (e.g., coronary computed tomography angiography and associated technologies). These less invasive diagnostic options have been recognized by private insurers, health associations, and other health systems as a preferred option for diagnosing coronary arterial disease. The Committee strongly encourages CMS to assess the benefits to patient care and savings to Federal health programs these less invasive options represent, when determining reimbursement policies.
The Committee requests an update in the fiscal year 2021 Congressional Justification on the diagnostic options available under CMS-administered health programs for coronary arterial disease.

Action Taken or To Be Taken

CMS is committed to addressing barriers to health care innovation and ensuring Medicare beneficiaries have access to critical and life-saving new cures and technologies that improve beneficiary health outcomes. Identifying and developing appropriate payment policies that aim to achieve better care and improved health for Medicare beneficiaries is a priority for CMS.

Medicare does cover some non-invasive and minimally invasive diagnostic options for coronary arterial disease. For example, Medicare covers Positron Emission Tomography (PET) scans performed at rest or with pharmacological stress used for non-invasive imaging of the perfusion of the heart, for the diagnosis and management of patients with known or suspected coronary arterial disease, using the FDA-approved radiopharmaceutical ammonia N-13. Through local coverage determinations, Medicare covers coronary computed tomography angiography for the evaluation of suspected symptomatic coronary arterial disease and for the detection of structural and morphologic intra- and extra-cardiac conditions. Medicare also covers coronary computed

tomography angiography for a number of indications, including in lieu of an imaging stress test for a patient presenting with chest pain syndrome. These are just a few examples of the non-invasive and minimally invasive diagnostic options that are covered by Medicare. In addition, Medicare Administrative Contractors are currently reviewing comments on proposed local coverage determinations to expand coverage of coronary computed tomography angiography.

Ambulatory Surgical Centers - The Committee requests an update on any increased costs to the Medicare program and its beneficiaries due to the potential migration of procedures from ambulatory surgical centers (ASCs) to higher cost settings. The update should examine volume changes over the past ten years and identify whether there are procedures that are migrating from ASCs to higher cost settings. The update also should include any recent changes in the ASC payment system to address migration of procedures.

Action Taken or To Be Taken

Under the Medicare program, there are several services which may be furnished in one of multiple settings, such as the hospital outpatient department (HOPD), the Ambulatory Surgical Center (ASC) or the physician office setting. CMS shares concerns about the potential for inappropriate migration of services from lower cost settings to higher cost settings and seeks to promote "site-neutral" payments to the extent permitted by law.

Medicare payment in the ASC setting uses the relative payment weights for surgical procedures under the Hospital Outpatient Prospective Payment System (OPPS) as the basis for the payment groups and the relative payment weights for surgical procedures performed in an ASC. These ASC payment weights are then scaled to maintain annual budget neutrality within the ASC payment system. Medicare payments for similar services furnished in HOPDs are generally higher than in the ASCs while Medicare payments for similar services in the physician office setting are generally lower than in the ASC setting.

In 2019, Medicare adopted a policy to update the ASC payment rates by the same rate update factor applied to hospital payment rates (i.e., the hospital market basket) rather than the Consumer Price Index for all Urban Consumers (CPI-U). This policy was established as a five year payment policy to determine whether the higher rate update encouraged an appropriate migration of services from the hospital setting to the ASC setting while not inappropriately moving services from the physician office setting to the ASC setting.

In 2017, 3.4 million fee-for-service (FFS) Medicare beneficiaries were treated in the 5,603 ASCs certified to provide services to Medicare beneficiaries. From 2012 to 2016, the number of ASCs increased by an average annual rate of 1.0 percent. In 2017, the number of ASCs increased 2.4 percent. From 2012 through 2016, the volume of services per FFS beneficiary increased by an average annual rate of 1.2 percent. In 2017, volume increased by 1.7 percent.[1]

ASCs furnish covered surgical services and related ancillary services to patients who do not require hospitalization and for which the expected duration of services does not exceed 24 hours following admission. Services excluded from Medicare payment in ASCs are those procedures that pose a significant safety risk to patients or are expected to require active medical monitoring at midnight on the day of the procedure when furnished in an ASC. The 20

[1] Figures based on MedPAC's March 2019 Report to Congress, pp 127-147.

most frequently provided ASC services in 2018 were similar to those provided in 2012. As of 2018, there are over 3,900 ASC covered surgical procedures.

Below are some summary data pertaining specifically to ASCs, including relevant changes in the volume of key services. The data show changes in the share of volume in the HOPD setting, ASC setting, and physician office setting for certain services out of all three settings between 2014 and 2018. While it is possible to assess the number of procedures performed in various settings over time, it is difficult to determine whether there is a true migration of services since factors such as beneficiary enrollment, severity of illness, access in rural and urban areas, and physician and patient preference can affect the volume of services furnished within a given service setting or even a given facility.

Among the top 100 procedures by Medicare ASC expenditures in 2018, between 2014 and 2018, the share of ASC utilization increased while the share of utilization in the HOPD and/or physician office setting decreased for 82 procedures. Increases in the share of ASC utilization were between 0 and 26.3 percentage points. Certain notable increases in the share of ASC utilization between 2014 and 2018 among the top 100 procedures by Medicare ASC expenditures in 2018, include:

- CPT code 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver) – the share of utilization decreased 23.0 percentage points in the HOPD setting and decreased by 0.6 percentage points in the office setting while the share of utilization in the ASC increased 23.6 percentage points from 2014 to 2018. ASC utilization increased by 18,225 procedures in 2018 when compared to 2014. Total utilization for this procedure across all three settings increased by 27,318 claims in 2018 when compared to 2014.

- CPT code 63650 (Implantation of neurostimulator electrode array) – the share of utilization decreased 6.4 percentage points in the HOPD setting and decreased by 8.6 percentage points in the office setting while the share of utilization in the ASC increased 15.0 percentage points from 2014 to 2018. ASC utilization increased by 52,159 procedures in 2018 when compared to 2014. Total utilization for this procedure across three settings increased by 71,091 claims in 2018 when compared to 2014.

- CPT code 63655 (laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural), the share of utilization decreased 24.0 percentage points in the HOPD setting and decreased by 0.4 percentage point in the physician office setting, while the share of utilization increased 24.4 percentage points in the ASC setting. ASC utilization increased by 4,114 procedures in 2018 when compared to 2014. Total utilization for this procedure across all three settings increased by 7,529 claims in 2018 when compared to 2014.

- CPT code 64561 (Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed), the share of utilization decreased 2.5 percentage points in the HOPD setting and the share of utilization decreased by 17.4 percentage points in the physician office setting while the share of utilization increased by 19.9 percentage points in the ASC setting. ASC utilization increased by 2, 329 procedures in 2018 when compared to 2014. Total utilization for this procedure across all three settings decreased by 1,183 claims in 2018 when compared to 2014.

Among the top 100 procedures by Medicare ASC expenditures in 2018, between 2014 and 2018, the share of utilization decreased in the ASC and increased in the HOPD and/or office settings for 18 procedures. Decreases in the share of ASC utilization were between 0 and 5.7 percentage points. Of these 18 procedures, the largest declines in ASC utilization were for:

- CPT code 45384 (Colonoscopy with lesion removal)[2] – ASC utilization declined by over 34,400 procedures in 2018 when compared to 2014 (a decline in ASC utilization of 33 percent). Additionally, the share of utilization in the HOPD decreased by 0.5 percentage points and utilization in the ASC decreased 0.2 percentage points while the share of utilization in the office setting increased 0.7 percentage points from 2014 to 2018. Total utilization for this procedure across all three settings decreased by 57,918 claims in 2018 when compared to 2014.

- CPT code 43235 (Esophagogastroduodenoscopy) – ASC utilization declined by 15,100 procedures in 2018 when compared to 2014 (a decline in ASC utilization of 11 percent). Additionally, the share of utilization in the HOPD increased 1.8 percentage points while the share of utilization in the office setting decreased 0.5 percentage point and utilization in the ASC decreased 1.3 percentage points from 2014 to 2018. Total utilization for this procedure across all three settings decreased by 23,819 claims in 2018 when compared to 2014.

- CPT code 28285 (Repair of hammertoe) – ASC utilization declined by over 6,500 procedures in 2018 when compared to 2014 (a decline in ASC utilization of 11 percent). Additionally, the share of utilization in the HOPD increased 1.5 percentage points while the share of utilization in the office setting decreased 1.3 percentage points and the share of utilization in the ASC decreased 0.2 percentage points from 2014 to 2018. Total utilization for this procedure across all three settings decreased by 11,805 claims in 2018 when compared to 2014.

- CPT code 49505 (Repair initial inguinal hernia) – ASC utilization declined by over 4,400 procedures in 2018 when compared to 2014 (a decline in ASC utilization of 23 percent). Additionally, the share of utilization in the HOPD increased 0.2 percentage point while the share of utilization in the office setting decreased by 0.1 percentage point and the share of utilization in the ASC decreased 0.1 percentage point from 2014 to 2018. Total utilization for this procedure across all three settings decreased by 17,989 claims in 2018 when compared to 2014.

Among the top 100 procedures by Medicare ASC expenditures in 2018, between 2014 and 2018, the share of utilization decreased in the ASC and HOPD setting but increased in the physician office for eight procedures.

- CPT code 14040 (Skin tissue rearrangement)
- CPT code 14060 (Skin tissue rearrangement)
- CPT code 15260 (Insertion of cardiac catheter)
- CPT code 30140 (Resect inferior turbinate)

[2] Note, CPT code 45384 is one over 30 colonoscopy codes payable in the ASC setting and is not the most commonly performed colonoscopy procedure in the ASC setting. Additionally, implementation of National Correct Coding Initiative edits that were implemented in recent years may have contributed to the decline in appropriate utilization of this procedure code.

- CPT code 43249 (Esophagogastroduodenoscopy)
- CPT code 45384 (Colonoscopy with lesion removal)
- CPT code 58558 (Hysteroscopy biopsy)
- CPT code 66821 (After cataract laser surgery)

Among the top 100 procedures by Medicare ASC expenditures in 2018, between 2014 and 2018, the share of utilization decreased in the ASC and office setting but increased in the HOPD setting for six procedures.

- CPT code 14301 (Skin tissue rearrangement)
- CPT code 28285 (Repair of hammertoe)
- CPT code 43235 (Esophagogastroduodenoscopy)
- CPT code 49505 (Repair initial inguinal hernia)
- CPT code 49650 (Laparoscopy)
- CPT code 52235 (Cystoscopy and treatment)

Among the top 100 procedures by Medicare ASC expenditures in 2018, between 2014 and 2018, the share of utilization decreased in the ASC but increased in both the physician office setting and the HOPD setting for four procedures.

- CPT code 28750 (Fusion of big toe joint)
- CPT code 36561 (Insert tunneled central venous catheter)
- CPT code 43248 (Esophagogastroduodenoscopy)
- CPT code 52234 (Cystoscopy and treatment)

As previously noted, overall utilization may change due to a number of factors. We are cognizant of the incentive that comes with higher payments for the same service, after adjusting for factors such as severity of illness and provider access to care. Accordingly, we aim to encourage site-neutral payments to the extent feasible under existing Medicare law.

As mentioned earlier in this document, in the CY 2019 OPPS/ASC final rule with comment period (83 FR 59075 through 59079), we finalized a policy to update the ASC payment system rates using the hospital market basket update instead of the CPI-U for CY 2019 through 2023. We believe that this policy will help stabilize the differential between OPPS payments and ASC payments, given that the CPI-U has been generally lower than the hospital market basket, and encourage the migration of services from the hospital outpatient setting to the ASC setting as clinically appropriate.

At-risk Youth Medicaid Protection - The Committee encourages CMS to consider rulemaking related to section 1001 of the SUPPORT for Patients and Communities Act and include an update on these activities in the fiscal year 2021 CJ.

Action Taken or To Be Taken

Guidance to states on section 1001 of the SUPPORT for Patients and Communities Act is under development. To support states in their efforts to implement the provision, CMS hosted a webinar for state staff on strategies for connecting justice-involved populations to substance use disorder treatment. The webinar iterated the intersection of Medicaid and justice-involved populations, including state Medicaid coverage initiatives.

Birth Centers - The Committee is concerned that the U.S. spends significantly more per capita on childbirth than any other industrialized nation, with costs estimated to be well over $50 billion annually, and yet despite this investment continues to rank far behind almost all other developed countries in birth outcomes for both mothers and babies, including high rates of preterm birth, low birth weight, and high maternal and infant mortality. The Committee was pleased that the CMMI Strong Start Initiative was created to look at how three different models of care (Maternity Care Homes, Centering Group Model Prenatal Care, and Birth Centers) would impact these outcomes and the costs associated with childbirth. The Committee notes that findings of this five-year study showed no differences in cost or outcomes for the Maternity Care Home model, and some slight cost savings and improved rates of low birthweight for the Centering model. But the birth centers, which provided a midwife-led model of holistic care, showed significant cost savings and improved childbirth outcomes across all measures. The Committee urges CMS to widely disseminate these findings to payers and consumers. Since Medicaid is the primary payer for almost half of all childbearing women and newborns in this country, the Committee strongly urges CMS to develop a proposal for how it will increase access to birth centers and midwives in all state Medicaid programs, and incentivize this model of care for low-risk women. The Committee requests a report within 120 days of enactment of this Act.

Action Taken or To Be Taken

CMS is committed to improving health outcomes for all mothers and their children. CMS published its final evaluation of the Strong Start for Mothers and Newborns (Strong Start) Initiative in October 2018, and the final evaluation is available to the public at innovation.cms.gov, along with other helpful materials concerning Strong Start. On November 9, 2018, CMS issued an Informational Bulletin summarizing the evaluation findings and urging states to consider studying the availability of birth center care in their states. The Informational Bulletin also highlights mandatory coverage of nurse-midwife services under Medicaid (CFR 440.165) and options for covering freestanding birth center services under Medicaid. Further, a 2016 State Health Official Letter (SHO#16-006) clarifies how freestanding birth center services can be incorporated into Medicaid managed care contracts.

Certified Community Behavioral Health Clinics [CCBHC] - The agreement directs CMS to provide available cost information to the Committees no later than 30 days after enactment of this Act. CMS should include a preliminary analysis summarizing cost data, as well as compare actual data to the Congressional Budget Office estimate.

Action Taken or To Be Taken

The estimates made by the Congressional Budget Office (CBO) in 2014 are not comparable to the expenditure data CMS collects through the CMS-64 for a variety of reasons. In 2014, CBO estimated that the cost of the 223 demonstration would be $600 million from 2014-2019. According to CMS-64 reporting, estimated expenditures in the first two years of the demonstration (federal share) were $803,481,460. These expenditures should not be considered final, as states have up to two years make adjustments to their claims as outlined under section 1132 of the Social Security Act and the implementing regulations at 45 CFR, Part 95, Subpart A. It is important to note that these expenditures do not capture any potential savings in other health services (for example, reduced emergency room use or hospital use). They also do not take into account the cost of services provided without the demonstration under Medicaid state plan and waiver services, and thus cannot be directly

compared to the CBO estimates. ASPE is currently conducting an evaluation of the 223 demonstration project and as part of that evaluation, plans to analyze claims data to determine the cost of demonstration for Medicaid clients served in CCBHC as compared to similar clients that were not served in CCBHCs under Medicaid state plan and waivers. This information will be detailed in the final annual report to Congress in December 2021, and should allow an estimate of the cost of the program above normal state expenditures. In the meantime, HHS believes that the cost of the demonstration (with a duration as initially planned) is likely less than the expenditures reported, because participating states do provide a portion of the CCBHC covered services under the Medicaid state plan and waivers. Exact cost differences, however, are not yet known.

In addition to this information, HHS will be providing a third report to Congress which does detail rate-setting information for the clinics. The fourth report to Congress will incorporate a second year of cost-history. The fifth and final report to Congress will provide more information on the cost of the program above normal state expenditures.

Claim Payment Coordination - The agreement requests information in the fiscal year 2021 Congressional Justification that provides options to reform the identification of Medicare beneficiaries enrolled in Medicare Advantage or Part D plans by third party payers in situations where no-fault or liability insurance, or workers' compensation is involved.

Action Taken or To Be Taken

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation, collectively referred to as Non-Group Health Plan (NGHP) or NGHP insurance.

Section 111 NGHP Responsible Reporting Entities (RREs) have the ability to transmit a query file to request information regarding the Medicare status of injured parties to help determine whether liability insurance, no-fault insurance or workers' compensation claim information should be reported. Through this process, NGHPs may determine whether an individual is a Medicare beneficiary.

Clinical Laboratory Fee Schedule - The Committee is pleased that CMS developed and issued a panel pricing policy that ensures the agency is not paying more for a single clinical diagnostic laboratory test, or a group of individual clinical diagnostic tests, than it would for a clinical diagnostic laboratory testing panel that tests for the same analytic(s). This new policy was effective January 1, 2019, and the Committee requests that the agency submit a report no later than 90 days after enactment of this Act to the Committees on Appropriations, as well as the authorizing Committees of jurisdiction, on the status of the implementation of this new policy and the cost savings to the Medicare program.

Action Taken or To Be Taken

Section 216(a) of the Protecting Access to Medicare Act of 2014 added section 1834A to the Social Security Act, which significantly revised the Medicare payment methodology for certain clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS). Beginning on January 1, 2018, Medicare began using certain private payer rate information

reported by applicable laboratories to calculate Medicare payment rates for most laboratory tests paid under the CLFS. The use of market data to establish CLFS payment rates strengthens Medicare by paying more appropriately for laboratory services while maintaining beneficiaries' access to high quality laboratory services.

Prior to implementation of the Protecting Access to Medicare Act of 2014, automated test panels (ATPs) without a current procedural terminology (CPT) code assigned were paid at a bundled rate using a payment algorithm developed by HHS. However, section 216(a) of the Protecting Access to Medicare Act of 2014 established section 1834A of the Act, which generally requires that the Medicare payment rates for each clinical diagnostic laboratory test under the CLFS be an amount that is equal to the weighted median of the private payer rates for the test, based on the applicable information reported by applicable laboratories. This statutory requirement led to the discontinuation of the use of ATP payment algorithms that bundled component CPT codes.

However, separate from the ATP category of tests, certain laboratory panel tests have their own CPT code, which is applicable whether the laboratory bills for the CPT panel code or the separate component tests. In the case of these tests, per HHS policy, the laboratory should be paid the CPT panel code amount when applicable.

In order to ensure that the Centers for Medicare and Medicaid Services (CMS) is paying appropriately for those laboratory panel tests that have their own CPT code, CMS has taken the following steps:

- In 2019, CMS updated the claims processing system to detect these claims in an automated fashion and now automatically groups individual tests into the appropriate laboratory panel test CPT code and assigns appropriate payment accordingly. CMS has implemented these changes to the claims processing system through the following change request: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4299CP.pdf.

- The National Correct Coding Initiative manual has been revised to require laboratory panel tests to be billed with the panel test CPT code versus the individual components being billed separately. Please refer to https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, Chaps I, Section N. Laboratory Panel and X, Section C. Organ or Disease Oriented Panels. This change is reflected in subregulatory guidance in Change Request 11076 and associated MLN Matters. Please refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11076.pdf.

Given that changes to the claims processing system were implemented during 2019 and all 2019 claims have not yet been submitted, Medicare will continue to monitor for any impacts of these new edits as well as any potential cost savings to the Medicare program.

Dialysis-Related Amyloidosis - The Committee is concerned that patients suffering from Dialysis-Related Amyloidosis may not have access to FDA-approved treatments, including apheresis treatments administered in the dialysis facility. The Committee is particularly concerned that CMS has not acted in a timely manner in assigning an appropriate Medicare benefit category for such apheresis treatments, following FDA approval in 2015. The Committee urges CMS to complete its benefit category analysis and issue a determination as

soon as possible. The Committee directs CMS, in conjunction with FDA, to report to the Committee within 90 days of enactment of this act, on the status of CMS's benefit category analysis and expected timeline for determination.

Action Taken or To Be Taken

CMS is committed to supporting innovation through access to clinically appropriate cutting-edge therapies for beneficiaries to improve quality of care and reduce costs. Among our efforts is exploring how we can enhance pathways for promising new medical technologies, including for patients with dialysis-related amyloidosis, by providing greater certainty to patients, providers, and innovators about CMS authorities and processes. The U.S. Food and Drug Administration approved under its authority for humanitarian use exemptions a new treatment for dialysis-related amyloidosis that uses a device in which blood is taken from the patient, processed to remove an accumulation of certain molecules, and returned to the patient as part of a continuous procedure. CMS continues to broadly explore our authority to address access to innovative devices in this area.

Disproportionate Share Hospitals - The Committee is concerned about the effect Disproportionate Share Hospitals (DSH) funding cuts will have on providers, patients, and communities nationwide. The Committee directs CMS to study the effects of the DSH cuts, under current law, on hospitals ability to furnish care for those uninsured and underserved, and to train and retain quality staff.

Action Taken or To Be Taken

CMS is committed to protecting access to care for Medicaid beneficiaries while ensuring compliance with statutory requirements set by Congress. Currently, the Medicaid DSH allotment reductions are scheduled to go into effect on May 23, 2020, as a result of the recently enacted Further Consolidated Appropriations, 2020 (Pub. L. 116-94). On September 25, 2019, CMS published a final rule delineating the methodology to implement the annual allotment reductions. States have broad flexibility in how they may distribute their DSH allotments to hospitals in their state, and CMS will continue to provide states with technical assistance on how the statutorily mandated DSH allotment reductions will impact the availability of additional funding available to their state.

Duchenne/Becker ICD10 Code - The Committee is aware of the addition of the new ICD10 code for Duchenne/Becker to the CMS FY 2019 Coding Addenda. The Committee requests an update in the FY 2021 Congressional Justification regarding the rates of utilization for the newly established ICD10 code.

Action taken or to be taken

In 2018, 926 Medicare beneficiaries were furnished services for which claims were submitted with the Duchenne/Becker muscular dystrophy ICD10 code (G71.01). In 2019, 1703 Medicare beneficiaries were furnished services with this code. Table 1 shows these figures, as well as counts for other muscular dystrophy-related ICD10 codes. Table 2 shows beneficiary counts by type of service.

Table 1: Unique Fee-For-Service Beneficiary Counts for G71.xx Codes by ICD10 Code and Year

ICD10 Code	2017	2018	2019
G710 - Muscular dystrophy	22,103	18,906	
G7100 - Muscular dystrophy, unspecified		8,128	15,287
G7101 - Duchenne or Becker muscular dystrophy		926	1,703
G7102 - Facioscapulohumeral muscular dystrophy		594	1,468
G7109 - Other specified muscular dystrophies		2,298	5,581
G7111 - Myotonic muscular dystrophy	6,659	6,703	6,313
G7112 - Myotonia congenita	566	589	527
G7113 - Myotonic chondrodystrophy	65	74	48
G7114 - Drug induced myotonia	68	40	22
G7119 - Other specified myotonic disorders	975	998	861
G712 - Congenital myopathies	2,211	2,076	1,859
G713 - Mitochondrial myopathy, not elsewhere classified	1,713	1,818	1,720
G718 - Other primary disorders of muscles	1,549	1,438	1,331
G719 - Primary disorder of muscle, unspecified	1,528	1,731	1,411
Total Beneficiary Count with G71.xx code[1]	**32,658**	**31,899**	**28,757**

1. ICD10 code beneficiary counts will not sum to total, since a beneficiary may have more than 1 G71.xx code in the year.

Table 2: Unique Fee-For-Service Beneficiary Counts for G71.xx Codes by Claim Type and Year

	Beneficiary Counts, all G71.xx codes			Beneficiary Counts, G71.01 Only	
Claim Type	**2017**	**2018**	**2019**	**2018**	**2019**
DME	6,430	6,200	5,291	220	381
Home Health	3,792	3,465	2,973	59	172
Hospice	857	901	808	11	28
IP	6,179	5,857	5,007	137	354
OP	14,014	14,041	12,775	357	778
Physician	25,022	24,697	22,038	622	1,318
SNF	1,481	1,487	1,366	16	46
Total Beneficiary Count[1]	**32,658**	**31,899**	**28,757**	**926**	**1,703**

1. Claim Type beneficiary counts will not sum to total, since a beneficiary may have more than one claim type with a G71.xx code in the year.

Extravasations - The Committee is aware of evidence demonstrating the prevalence of extravasations in nuclear medicine procedures. Extravasations of diagnostic radiopharmaceuticals negatively affect the sensitivity and quantification of nuclear medicine scans. Extravasations can affect disease staging and treatment assessment, result in unnecessary invasive procedures and additional radiation exposure, and lead to higher costs for patients and payers. The Committee encourages CMS to consider adding required monitoring of injection quality and submission of reportable extravasations to the Nuclear Regulatory Commission to its conditions of participation for nuclear medicine services. The Committee requests an update on this issue in the fiscal year 2021 Congressional Budget Justification.

Action Taken or To Be Taken

As required by section 1861(e) of the Social Security Act, hospitals must meet requirements that the Secretary finds necessary for the health and safety of individuals who are furnished services in a hospital. Through rulemaking, the Medicare conditions of participation (CoPs) for hospitals establish health and safety requirements. The nuclear medicine CoPs (42 CFR 482.53) require that nuclear medicine services meet the needs of patients and that radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.

In addition, a hospital's nuclear medicine services should be integrated into the hospital's Quality Assessment and Performance Improvement program to monitor the quality and safety of nuclear medicine services. This program requires the hospital to track adverse events and medical errors to find their causes and undertake preventive actions.

CMS must find a balance between including specific requirements necessary to ensure the health and safety of patients while deferring to providers to follow acceptable standards of practice. The CoPs do not include all aspects of care delivery. With respect to a requirement to report extravasations to the Nuclear Regulatory Commission, it is not clear what mechanism would be used for such reporting.

Health Insurance Exchange Transparency.—The Committee continues bill language that requires CMS to provide cost information for the following categories: Federal Payroll and Other Administrative Costs; Exchange related Information Technology [IT]; Non-IT Program Costs, including Health Plan Benefit and Rate Review, Exchange Oversight, Payment and Financial Management, Eligibility and Enrollment; Consumer Information and Outreach, including the Call Center, Navigator Grants and Consumer Education and Outreach; Exchange Quality Review; Small Business Health Options Program and Employer Activities; and Other Exchange Activities. Cost Information should be provided for each fiscal year since the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148). CMS is also required to include the estimated costs for fiscal year 2021.

Health Insurance Exchanges Transparency Table

Dollars in Thousands

Activity	FY 2010 Actual	FY 2011 Actual	FY 2012 Actual	FY 2013 Actual	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual	FY 2017 Actual	FY 2018 Actual	FY 2019 Actual	FY 2020 Enacted	FY 2021 President's Budget
Health Plan Bid Review, Management and Oversight	$ -	$ 300	$ 21,936	$ 40,595	$ 33,497	$ 43,960	$ 40,520	$ 39,846	$ 37,910	$ 45,797	$ 45,214	$ 18,300
Payment and Financial Management	$ -	$ 1,698	$ 24,998	$ 25,832	$ 49,615	$ 43,733	$ 51,325	$ 47,640	$ 45,141	$ 50,220	$ 63,438	$ 42,183
Eligibility and Enrollment 1/	$ -	$ 2,218	$ 3,433	$ 275,501	$ 339,754	$ 363,768	$ 445,249	$ 484,144	$ 392,660	$ 348,488	$ 358,938	$ 292,842
Consumer Information and Outreach	$ -	$ 2,427	$ 32,610	$ 701,075	$ 704,136	$ 753,238	$ 805,833	$ 640,232	$ 591,948	$ 579,088	$ 529,635	$ 306,550
Call Center (non-add)	*$ -*	*$ -*	*$ 22,000*	*$ 505,446*	*$ 545,600*	*$ 566,178*	*$ 563,638*	*$ 540,197*	*$ 525,326*	*$ 499,053*	*$ 442,700*	*$ 241,900*
Navigators Grants & Enrollment Assisters (non-add)	*$ -*	*$ -*	*$ -*	*$ 107,513*	*$ 97,152*	*$ 75,996*	*$ 99,677*	*$ 51,166*	*$ 12,720*	*$ 19,499*	*$ 20,835*	*$ 13,530*
Consumer Education and Outreach (non-add)	*$ -*	*$ -*	*$ 7,043*	*$ 77,436*	*$ 49,334*	*$ 54,897*	*$ 101,048*	*$ 16,599*	*$ 10,744*	*$ 11,231*	*$ 11,600*	*$ 11,850*
Information Technology	$ 2,346	$ 92,672	$ 166,455	$ 402,553	$ 770,957	$ 798,648	$ 664,083	$ 710,867	$ 767,413	$ 504,283	$ 612,358	$ 430,837
Quality	$ -	$ -	$ -	$ -	$ 17,189	$ 15,634	$ 11,736	$ 7,301	$ 7,240	$ 7,334	$ 8,000	$ 9,700
SHOP and Employer Activities	$ -	$ 366	$ 18,479	$ 25,076	$ 30,541	$ 42,717	$ 34,520	$ 16,500	$ 4,418	$ 2,117	$ 200	$ 200
Other Exchange	$ 1,879	$ 14,906	$ 13,738	$ 4,400	$ 6,728	$ 3,614	$ 12,032	$ 49,584	$ 31,196	$ 40,290	$ 89,321	$ 46,500
Federal Payroll and Other Administrative Activities	$ 429	$ 10,805	$ 43,493	$ 68,429	$ 80,000	$ 80,000	$ 85,000	$ 79,602	$ 70,892	$ 77,750	$ 77,750	$ 50,000
Total	$ 4,654	$ 125,392	$ 325,142	$ 1,543,461	$ 2,032,418	$ 2,145,312	$ 2,150,297	$ 2,075,714	$ 1,948,818	$ 1,655,367	$ 1,784,855	$ 1,197,112

1/ Funding for Enrollment Assisters ended in FY 2017.

NOTE: Fiscal years 2010 through 2019 include obligations as of September 30 of each year.

NOTE: Before the Exchanges were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

NOTE: The FY 2020 Enacted level is an estimate as of January 2020.

Home Visiting Programs - The Committee recognizes the wide range of improved outcomes and cost-savings that evidence-based home visiting programs provide to first-time at-risk mothers and their children. However, the Committee is concerned that the lack of clarity on how to use Medicaid dollars alongside other funding sources has slowed or stopped state action to effectively leverage Medicaid to support home visiting services. The Committee directs the Centers for Medicaid and CHIP Services (CMCS) to build on its 2016 Joint Informational Bulletin on this topic to clarify how Medicaid dollars can be blended and braided appropriately to reach eligible families, and also provide streamlined coverage options for home visiting. In addition, once CMCS has finalized its November 2018 Medicaid Managed Care rule, the Committee directs CMCS to update its November 2017 Informational Bulletin on Delivery System and Provider Payment Initiatives under Medicaid Managed Care Contracts to explain how states can use the revised managed care authority to fund evidence-based home visiting programs.

Action Taken or To Be Taken

CMS is committed to improving health outcomes for all mothers and their children. CMS continues to work with its HHS partners, including HRSA, which administers the Maternal, Infant, and Early Childhood Home Visiting Program. CMS assists states that choose to design a Medicaid benefit package to provide home visiting services for pregnant and postpartum women, and for families with young children. CMS believes states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations. There are various Medicaid authorities, including state plan amendments, Medicaid demonstration waivers, and managed care, that states can utilize to incorporate components of home visiting services into their Medicaid programs.

For example, CMS has approved state requests to pilot home visiting programs under section 1115 demonstrations, including requests from Maryland and Rhode Island. Section 1115 demonstrations offer states additional freedom to test and evaluate innovative solutions to improve the quality, accessibility, and health outcomes of women and infants enrolled in Medicaid. Under its “Maryland Health Choice” demonstration, Maryland is testing an evidence-based Home Visiting Services (HVS) Pilot, through which Medicaid expenditures for evidence-based home visiting services to promote enhanced health outcomes, whole person care, and community integration for high-risk pregnant women and children up to two years of age are permitted.

Rhode Island operates a statewide family home visiting services program through its section 1115 demonstration, entitled the “Rhode Island Comprehensive Demonstration”. Under this demonstration, Medicaid expenditures for evidence-based home visiting services under the Nurse-Family Partnership and Healthy Families America for qualified beneficiaries are permitted.

Additionally, in 2017, CMS launched the Maternal and Infant Health Initiative Value-Based Payment (VBP) Initiative through the Innovation Accelerator Program to provide technical support opportunities for Medicaid/CHIP agencies. Through this initiative, states can select, design, and test VBP approaches to sustain care delivery models that demonstrate improvement in maternal and infant health outcomes, including home visiting.

Hospital-Acquired Conditions - The agreement supports an evaluation of the efforts to reduce Hospital Acquired Conditions, outlined in House report 116-62, and directs the Secretary to include the results of the evaluation in the fiscal year 2021 Congressional Justification.

Hospital-Acquired Pressure Ulcers - The agreement requests an update in the fiscal year 2021 Congressional Justification on reducing pressure ulcer discharges.

Action Taken or To Be Taken

CMS is committed to ensuring beneficiaries have the highest quality of care, and pressure ulcers are a critical area to address. CMS has worked to add quality measures addressing pressure ulcers to its quality reporting and value-based payment programs. Specifically, in the hospital setting, we have one composite measure, the *Patient Safety and Adverse Events* composite measure, which provides a performance score based on how often patients have certain complications related to inpatient hospital care. There are ten complications that are part of this measure, one of which is *Pressure Ulcer Rate* This composite measure is reported on Hospital Compare and is also included in the Hospital-Acquired Conditions Reduction program and the Hospital Value-Based Purchasing program. In addition, there are quality measures addressing pressure ulcers in all of the quality reporting programs for post-acute care providers (long-term care hospitals, inpatient rehabilitation hospitals, skilled nursing facilities, and home health agencies).

Additionally, a payment policy was established in 2008 under which Medicare does not make additional payments for inpatient hospital care for selected hospital-acquired conditions if the condition was not present on admission, and if the condition could reasonably have been prevented through the application of evidence-based guidelines. CMS has selected certain conditions for this payment policy, and one category of conditions is Pressure Ulcer Stages III & IV. If a selected condition results in assignment of a case to a secondary diagnosis that would lead to a higher payment, hospitals will not receive the higher payment amount but will be paid as though the secondary diagnosis was not present. There is a similar provision in the Medicaid program implemented in 2011, under which States may not pay for services related to certain provider-preventable conditions in hospitals. This includes most hospital-acquired conditions selected under the Medicare provision described above, as well as provider-preventable conditions identified in a State Medicaid plan.

Hospital Outpatient Prospective Payment - The Committee is concerned about the rule entitled ''Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs'' (83 Fed. Reg. 58818, November 21, 2018) and urges CMS to reconsider this rule after taking into account harmful effects to hospitals that are designated as a Sole Community Hospital, or that are located in a HRSA-designated Health Professional Shortage Area (HPSA). The Committee requests a report within 180 days of enactment of this Act detailing the financial impacts of this rule on these two categories of hospitals and the impact of the rule on the health provider workforce within HRSA-designated HPSAs.

Action Taken or To Be Taken

Approximately 60 million people live in rural areas across the United States – including millions of Medicare and Medicaid beneficiaries. CMS recognizes the many obstacles that rural Americans face when accessing healthcare services, including a fragmented healthcare delivery system, stretched and diminishing rural health workforce, unaffordability of insurance, and lack of access to specialty services and providers. CMS launched the agency's first Rural Health Strategy in May 2018 to help improve access to high quality, affordable healthcare in rural communities. The strategy is intended to provide a proactive and strategic focus on healthcare

issues across rural America to ensure the nearly one in five individuals who live in these areas have access to care that meets their needs.

With respect to the Calendar Year 2019 Outpatient Prospective Payment System Final Rule and its impact on Sole Community Hospitals, the rule includes estimated impacts of the finalized policies and specifically, estimates a 1.1 percent increase in payments for sole community hospitals and a 1.6 percent increase for other rural hospitals (83 FR 59163).

Limited Wraparound Coverage - The Committee strongly urges CMS to extend the pilot program established by a final regulation published on March 18, 2015, to allow limited wraparound benefits, or supplements, to individual health insurance coverage (or Basic Health Plan coverage). Wraparound coverage is a specialized offering targeted to help part-time workers and retirees whose employers or former employers meet standards of responsibility and have agreed to provide this supplemental coverage as an option. The Committee recommends this pilot program be made permanent. The Committee requests a report within 90 days of enactment of this Act on the status of the program.

Action Taken or To Be Taken

As stated in the final rule on Health Reimbursement Arrangements and Other Account-Based Group Health Plans (84 FR 28888), CMS does not intend to extend the pilot program for limited wraparound coverage, due to minimal take up and overlap with various other benefit options, such as the new excepted benefit HRA. These new benefit options , like the limited wraparound coverage excepted benefit, can be used for cost sharing under and expenses for services not covered by individual health insurance coverage, while not causing covered individuals to be ineligible for the premium tax credit.

Medicaid Dental Audits - The Committee is concerned that failure to use professional guidelines or established state Medicaid manual parameters in the auditing process can result in inaccurate and unreasonable Medicaid dental audits. These practices deter providers from participation in the program and negatively affect care to patients. The Committee therefore directs CMS to instruct contracted auditors to utilize dental profession clinical guidelines, best practices, and policies of the American Academy of Pediatric Dentistry and American Dental Association when conducting dental audits, and require independent peer-to-peer review. The Committee directs CMS to report back to the Committee within 90 days of enactment of this Act on steps taken to address these auditing concerns.

Action Taken or To Be Taken

The Medicaid program is jointly administered by CMS and states. State Medicaid Agencies (SMA) administer the program on a day-to-day basis. Accordingly, such states are responsible for establishing, within broad federal guidelines, various Medicaid program requirements such as who will be eligible for benefits, what benefits will be covered, who will be eligible to provide services and the payment policies pursuant to which reimbursement will be made. This gives states tremendous flexibility in the design of their respective programs and results in great variation among Medicaid programs.

In addition to state efforts, CMS' Unified Program Integrity Contractors (UPICs) are authorized to conduct audits of Medicaid providers under section 1936 of the Social Security Act, including dental providers. The design of the Medicaid UPIC work reflects the dynamic of a state administered program. UPICs work collaboratively with SMAs to determine areas of audit,

i.e., dental services, as well as the relevant coverage policies to be applied in connection with such audits. In addition, as a matter of practice, UPICs verify whether their auditors meet the requisite qualifications established by the SMA. Further, UPIC auditors follow the dental policies that are established by the SMA. These policies are the official policies providers are to follow in order to receive reimbursement. If a SMA has incorporated the American Academy of Pediatric Dentistry or American Dental Association clinical guidelines, best practices, and/or policies into their state policy, then they would be considered part of the audit.

Medicare Promotion - The Committee directs CMS to avoid taking any action that actively promotes one form of Medicare coverage over another, particularly with respect to the choice between traditional Medicare and Medicare Advantage (MA). The Committee further directs CMS to design and maintain its online coverage options tool in a manner that provides complete and unbiased information, particularly as CMS works to replace the Medicare Plan Finder with the new Medicare Coverage Tools platform. Furthermore, CMS should remain objective and neutral in its education and outreach materials concerning options that beneficiaries have during the open enrollment period and at any other time.

Action Taken or To Be Taken

Our goal at CMS is to ensure that the information provided to consumers about Medicare is clear, accurate and reliable, and that it provides balanced descriptions about the options for Medicare coverage. CMS is committed to continually improving our outreach and education materials to help bring clarity to Medicare coverage decisions by beneficiaries.

As part of every Open Enrollment, CMS executes a robust and multi-faceted campaign, which encourages consumers to review their Medicare coverage, compare alternatives and make an informed decision about options for the upcoming year. Our materials cover a wide range of topics, including the details of Original Medicare, and are informed by extensive research with Medicare beneficiaries and engagement with partners and stakeholders.

Open Enrollment is a critical time for people to compare coverage options, research all available health and drug plans, and fully understand any changes in costs and benefits. Most of our messaging during this time drives people to the Medicare Plan Finder, which allows people with Medicare to compare Original Medicare with Medicare Advantage Plans and Prescription Drug Plans in their area. For the first time in a decade, the Medicare Plan Finder was recently modernized and redesigned. The new Plan Finder provides Medicare beneficiaries and their caregivers with a personalized experience through a mobile friendly and easy-to-read design that will help them learn about different options and select coverage that best meets their health needs.

In addition to outreach occurring during Open Enrollment, the Medicare & You handbook mailed each fall to all beneficiary households describes all the options for Medicare coverage. The 2020 Medicare & You handbook provides additional details clarifying the distinctions between Original Medicare and Medicare Advantage. For example, the 2020 Handbook notes that in most cases under Medicare Advantage, a beneficiary will need to use doctors who are in the plan's network for non-emergency or non-urgent care.

CMS ensures that Medicare beneficiaries receive clear and accurate details that they need to make the choices that best fit their needs. As with all of our outreach, CMS remains committed to providing the best possible information and customer experience to all people with Medicare.

Medicare Area Wage Index - The agreement directs CMS to provide a report to the Committees on its methodology for calculating the labor-related share (LRS) percentage used in the proposed rule entitled "The Inpatient Prospective Payment System and the Long-Term Care Hospital Prospective Payment System for fiscal year 2020". The report shall fully describe all methodologies, allocations, and assumptions; and provide a schedule(s) of the calculation used to derive the LRS percent.

Action Taken or To Be Taken

The national hospital Inpatient Prospective Payment System (IPPS) base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. Base payment rates, including the labor-related share and nonlabor-related share, are specified in section 1886(d) of the Social Security Act, as is the Secretary's authority to adjust the labor-related share. Specifically, section 1886(d)(3)(E) of the Social Security Act directs the Secretary to adjust the labor-related share and to estimate, from time to time, the proportion of hospital costs that are labor-related.

The labor-related share includes operating costs that are attributable to wages and salaries, employee benefits, professional fees, administrative and facilities support services, installation, maintenance, and repair services, and all other labor related services. In the FY 2020 IPPS proposed rule, CMS proposed the same labor-related share of 68.3 percent that applied for FY 2019 after notice and comment and that CMS had finalized when it rebased and revised the hospital market in the FY 2018 final rule after notice and comment. In the FY 2020 IPPS final rule, CMS finalized the policy as proposed. Therefore, CMS continues to use a labor related share of 68.3 percent for discharges occurring on or after October 1, 2019 (84 FR 42325).

Mental Health Parity - The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted more than 10 years ago to prevent group health plans and health insurance providers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on qualifying mental health benefits than on medical or surgical benefits. The Committee is aware of instances where insurers, covered health care plans and managed care organizations (MCO), including MCOs that manage state Medicaid programs, may be imposing conditions for access to treatment for mental health services, including services for Down syndrome and autism spectrum disorder, that are not imposed on medical or surgical benefits. These limitations may include parent or caregiver participation requirements, preauthorization processes, location of services exclusions, and fail-first policies. The Committee directs CMS to ensure compliance with MHPAEA by regularly issuing guidance to insurers, covered healthcare plans, and MCOs, which outlines how compliance with MHPAEA is to be achieved. This guidance should include recommendations for appropriate training of personnel responsible for benefit authorizations, adverse benefit determinations, and payments. These agencies should ensure that such informational bulletins also provide appropriate consumer and complaint information that helps patients take action when they encounter MHPAEA violations.

Action Taken or To Be Taken

HHS is committed to enforcing mental health and substance use disorder parity requirements in the areas in which it has authority. HHS has primary enforcement authority with respect to The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and other applicable Federal laws, over non-Federal governmental plans. Non-Federal governmental plans are group health plans that are sponsored by public employers

other than the Federal government, such as states, counties, school districts, and municipalities for their employees. Sponsors of self-funded, non-Federal governmental plans may opt out of certain requirements of Title XXVII of the Public Health Service (PHS) Act, including MHPAEA. HHS reviews self-funded, non-Federal governmental plans' opt-out elections to ensure compliance with the requirements for opting out of the applicable PHS Act provisions, including MHPAEA. HHS has the authority to investigate, for compliance with MHPAEA, non-Federal governmental plans that have not opted out when HHS receives information that indicates potential noncompliance with respect to MHPAEA or other applicable laws. In addition, HHS has the authority to initiate a market conduct examination to determine whether a non-Federal governmental plan that has not filed a valid MHPAEA opt-out is out of compliance with MHPAEA.

HHS' MHPAEA enforcement authority with respect to health insurance issuers selling health insurance products in the individual and group markets extends only to states that elect not to enforce or the Secretary determines are failing to substantially enforce MHPAEA. HHS is currently enforcing MHPAEA with respect to issuers in four states: Missouri, Oklahoma, Texas, and Wyoming. In general, HHS reviews health insurance policy forms of issuers in the individual and group markets for compliance with MHPAEA and other Federal requirements prior to the products being offered for sale in these states. Through this process, parity issues are identified by HHS reviewers and are addressed and corrected by the issuers before individuals and groups enroll in the products. HHS additionally may conduct market conduct examinations of issuers in these states, as well as in states that have a collaborative enforcement agreement with HHS if the state requests such an examination in order to obtain issuer compliance with a Federal requirement. HHS will enter into a collaborative enforcement agreement with any state that is willing and able to perform regulatory functions but lacks enforcement authority.

In addition to enforcing MHPAEA requirements, HHS also works with plans and issuers to help them understand and comply with MHPAEA and ensure that individuals receive the benefits to which they are entitled. HHS also collaborates with State regulators, both individually and through the National Association of Insurance Commissioners (NAIC), as well as with the Departments of Labor and the Treasury, to issue guidance to address frequently asked questions from stakeholders and provide technical assistance in an effort to increase understanding and compliance. Compliance assistance is a high priority for HHS, and HHS emphasizes the importance of assisting plans and issuers that are working to comply with MHPAEA requirements.

In collaboration with the Department of Labor, HHS has published numerous FAQs and other guidance documents intended to better educate consumers, issuers, group health plans, state regulators, and other stakeholders on how to identify potential violations of the Non-Quantitative Treatment Limitations (NQTLs) requirements of MHPAEA. This guidance includes examples of plan or policy language that could be considered a red flag that an issuer or plan may be imposing impermissible NQTLs. CMS has also issued guidance, FAQs, and toolkits intended to better educate states, Medicaid MCOs, and beneficiaries on the application of certain mental health and substance use disorder provisions of MHPAEA to the coverage provided to enrollees of Medicaid MCOs, Medicaid alternative benefit plans, and the Children's Health Insurance Program.

Each year, CMS, a component of HHS, issues a report to increase transparency with respect to enforcement of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). CMS has taken action to ensure compliance with MHPAEA

since its enactment in 2008. The most recent report is available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/FY2018-MHPAEA-Enforcement-Report.pdf

National Health Expenditure (NHE) Database - The Committee is concerned about discrepancies between official CMS estimates and industry surveys suggesting that CMS understates the growth of private health insurance and total health spending at the household level. If private health spending is under reported in NHE, estimates of total health U.S. spending may be too low as well. The Committee requests that CMS include information in its FY 2021 budget justification explaining its methodology for including data in the National Health Expenditure database, as well as an analysis of how CMS-published data compares to other comparable information on health expenditures.

Action Taken or To Be Taken

The National Health Expenditures (NHE) include both historical and projected NHE estimates.

NHE Historical: The National Health Expenditure Accounts (NHEA) are the official estimates of total health care spending in the United States. Dating back to 1960, the NHEA measures annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care. The data are presented by type of service, sources of funding, and type of sponsor. The NHEA are generally compatible with a production-based accounting structure such as the National Income and Product Accounts, but include a more complete picture of the health care sector. Using an expenditures approach to national economic accounting, the NHEA identifies all final consumption of health care goods and services as well as investment in a given year that is purchased or provided by direct or third party payments and programs. Three primary characteristics of the NHEA flow from this framework. First, the NHEA are comprehensive because they contain all of the main components of the health care system within a unified mutually exclusive and exhaustive structure. Second, the NHEA are multidimensional, encompassing not only expenditures for medical goods and services, but also the payers that finance these expenditures. Third, the NHEA are consistent because they apply a common set of definitions that allow comparisons among categories and over time.

The information contained in the NHEA can be used to study numerous topics related to the health care sector including, but not limited to, changes in the amount and cost of health services purchased and the payers or programs that provide or purchase these services, the economic causal factors at work in the health sector, the impact of policy changes, and comparisons at the international level.

More information on the methodology can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/DSM-16.pdf.

NHE Projections: The Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) produces short-term (10-year) projections of health care spending for categories in the National Health Expenditure Accounts (NHEA) on an annual basis. The NHE projections consist of time series for all of the major spending categories in the NHEA. These categories include trends in aggregate medical spending, medical services consumed, sources of payment, and sources of financing.

For the current spending projections, CMS primarily utilizes the standard NHE Econometric Model, with adjustments to model projections for specific effects as needed. The NHE Econometric Model is based on a multi-equation structural econometric model that reflects relationships in historical time-series data and encompasses the health system as a whole. The primary focus of the NHE Econometric Model is to produce projections of future health care spending by private health insurers, by consumers on an out-of-pocket basis, and by other private payers that are consistent with exogenous projections for Medicare, Medicaid, CHIP, and key macroeconomic variables. Key exogenous inputs to the model include the most recent available macroeconomic and demographic assumptions from the Social Security Administration (SSA), as well as actuarial projections for Medicare, Medicaid, and CHIP spending and enrollment. CMS also projects residual spending for other government programs (excluding the programs mentioned above) to provide a comprehensive projection of all spending within the NHEA.

More information on the methodology can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf

New Medical Residency Training Programs - Given the growing physician workforce shortage, the Committee strongly encourages CMS to utilize its discretion to extend the time period described in section 413.79(e) of title 42, Code of Federal Regulations, for new residency programs in areas facing physician shortages before a full-time equivalent resident cap is applied, as authorized in P.L. 105–33. Moreover, the Committee recommends that the agency meet with physician, hospital, and other industry stakeholders from underserved areas to better understand changes in population health. The agency shall provide an update to the Committees on Appropriations on these efforts within 90 days of enactment of this Act.

Action Taken or To Be Taken

This Budget includes a proposal that would consolidate Federal GME spending from Medicare, Medicaid, and the Children's Hospitals GME programs into a single grant program for teaching hospitals, and direct funding toward physician specialty and geographic shortage areas, with particular focus on medically underserved communities and health professional shortages. Patients and providers would be well served by these commonsense reforms and the new grant program would be operated jointly by the Health Resources and Services Administration and CMS.

Nonemergency Medical Transportation - The agreement directs HHS to take no regulatory action on availability of NEMT service until the study described under the "Medicaid and CHIP Payment and Access Commission" header of this joint explanatory statement is complete.

Action Taken or To Be Taken

States have requested additional flexibility from this requirement due to challenges containing NEMT costs and addressing program integrity concerns. As noted in the Unified Agenda of Regulatory and Deregulatory Actions, the Administration plans to issue a request for information that will seek public input on whether the Assurance of Transportation in the Medicaid program remains administratively necessary given the delivery of healthcare both in terms of technological advances and the commercial market design. CMS will also request stakeholder comment regarding the merits of the transportation assurance on selected populations and

services e.g. maintain the assurance for EPSDT eligible individuals, pregnant women, individuals who are medically frail, and emergency transportation services.

Nurse Staffing Requirements - The Committee recognizes the link between appropriate nurse staffing levels and improved patient safety and outcomes. As part of its oversight function, CMS is charged with ensuring that Medicare-participating hospitals meet important patient safety standards, including meeting appropriate nurse staffing requirements. The Committee requests that CMS provide, in its fiscal year 2021 Congressional Justification, information relating to its criteria for evaluating appropriate nurse staffing.

Action Taken or To Be Taken

Section 1861(e) of the Social Security Act provides that (1) hospitals participating in Medicare must meet certain specified requirements and (2) the Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals. As noted by some stakeholders and commenters, staffing in hospitals has a substantial impact on the quality of care and outcomes patients' experience. In recognition of the importance of nursing staff, the Medicare Conditions of Participation for hospitals require all hospitals provide 24-hour nursing services furnished or supervised by a registered nurse. Hospitals must have a licensed practical nurse or registered nurse on duty at all times, except for certain rural hospitals that have in effect a 24-hour nursing waiver granted under 42 CFR 488.54(c) (42 CFR 482.23). Hospitals are surveyed to ensure they comply with Medicare's Conditions of Participation.

Nursing Home Safety - The Committee is concerned about the findings of the HHS Office of Inspector General (OIG) report entitled, ''CMS Guidance to State Survey Agencies on Verifying Correction of Deficiencies Needs to be Improved to Help Ensure the Health and Safety of Nursing Home Residents.'' The Committee requests a report within 60 days of enactment of this Act on the actions that CMS has taken to implement the OIG's recommendations. In addition, the report should include an assessment of whether the CMS Special Focus Facility Initiative has substantially improved the quality of care at underperforming nursing facilities and what, if any, improvements to the initiative need to be made.

Action Taken or To Be Taken

CMS bears the responsibility to develop and enforce quality and safety standards across the Nation's health care system, and is deeply committed to that job. Every nursing home resident deserves to be treated with dignity and respect, and all of our nursing home work at CMS is predicated upon that single goal. In April 2019, Administrator Verma announced CMS' five-part approach to ensuring safety and quality in America's nursing homes – Strengthen Oversight, Enhance Enforcement, Increase Transparency, Improve Quality, and Put Patients Over Paperwork.

In October 2019, CMS announced a major step in the Agency's efforts to ensure safety and quality for nursing home patients and residents. As part of continuing efforts to keep nursing home residents safe and respond to concerns about inconsistent and untimely inspections, CMS is strengthening the system it uses to hold inspectors accountable, the State Performance Standards System (SPSS). Nursing homes are inspected by State Survey Agencies (SSAs), and their inspections protect patients and residents by ensuring nursing homes comply with federal safety guidelines. Under the changes announced in the memorandum to states, CMS will, through the updated SPSS assessment tools, more rigorously and rapidly analyze SSA

performance to ensure inspections are timely and accurate. This includes new performance measures and stricter monitoring to ensure inspections are done in a fair, accurate, and timely manner, ensuring patient safety, and ensuring that enforcement actions – like civil money penalties – are applied consistently.

The Special Focus Facility (SFF) program was created in 1998 to target low-quality facilities for additional scrutiny. The SFF program focuses on nursing homes that have a track record of substandard quality of care. Although such facilities have sometimes incorporated enough improvement in the presenting problems to pass one survey, they have frequently manifested many problems on the next survey, often for many of the same problems as before. Such facilities with a "yo-yo" compliance history rarely addressed the underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.

Once a state selects a facility as an SFF, the SSA, on CMS's behalf, conducts a full, onsite inspection of all Medicare health and safety requirements every six months and recommends progressive enforcement (e.g., fines, denial of Medicare payment) until the nursing home either (1) graduates from the SFF program; or (2) is terminated from the Medicare and/or Medicaid program(s). The SSA will also apply progressively stronger enforcement actions in the event of continued failure to meet Medicare and/or Medicaid participation requirements. Enforcement sanctions will be of increasing severity for SFFs that do not make significant improvement. There are 15,000 nursing homes in the country, and almost 3,000 of these have a one-star rating on their health inspections. By contrast, there are only 88 SFF program slots, and only about 400 candidates for the program.

Pediatric Kidney Disease - The agreement encourages HHS to conduct a study of pediatric dialysis costs to ensure that the data being collected by CMS is accurate and report findings in the fiscal year 2021 Congressional Justification.

Action Taken or To Be Taken

The End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) base rate is adjusted for characteristics of both adult and pediatric patients and accounts for patient case-mix variability. The adult case-mix adjusters include five categories of age, body surface area, low body mass index, onset of dialysis, four comorbidity categories, and pediatric patient-level adjusters consisting of two age categories and two dialysis modalities. In addition, ESRD facilities are eligible to receive outlier payments for treating both adult and pediatric dialysis patients. The outlier services amounts are different for adult and pediatric patients due to differences in the utilization of separately billable services among adult and pediatric patients

A Technical Expert Panel (TEP) was held on December 6, 2018 to discuss options for improving data collection to refine the ESRD PPS case-mix adjustment model. CMS contracted with a data contractor to convene this TEP and conduct research and analysis to refine the case-mix adjustment model. The TEP comprised 16 expert stakeholders, including ESRD facilities, representatives of professional associations, independent academic clinical researchers, and patient advocates. In addition, a select number of observers attended, including representatives of governmental agencies and independent policy advisory groups. This TEP represented the first step in acquiring stakeholder and expert input to inform these refinements.

CMS sought input in the Calendar Year 2020 ESRD PPS proposed rule on options for improving the reporting of composite rate costs for the ESRD PPS, including for pediatric dialysis costs. We believe improved reporting of both patient level costs, as reported on claims,

and facility level costs, as reported on cost reports, is needed in order to obtain sufficient, high quality data to inform a refined case mix adjusted model for the ESRD PPS. We also sought comments regarding suggested specific changes to the cost reports or cost report instructions that would be most useful to improve the consistency of reporting across facilities. Regarding pediatric dialysis, CMS specifically sought input from stakeholders on whether pediatric and home dialysis costs accurately apportioned across cost components in cost reports and the costs incurred by pediatric dialysis units that do no vary at the patient-level. CMS noted in the rule that CMS will consider new input from stakeholders as we develop methodologies for implementing select changes to claims and cost reports that serve to elucidate composite rate costs.

Commenters highlighted that pediatric dialysis facilities are a special case, that a pediatric case mix adjuster is warranted, and that significant revisions to cost reports should be made to allow true cost of providing care to this special population to be adequately reported. CMS recognizes that the pediatric dialysis population has unique needs and that those needs must be closely examined. Our data analysis contractor held a Technical Expert Panel meeting in December 2019 to discuss pediatric dialysis.

Prior Authorization - The Committee is aware that Medicare Advantage (MA) plans have increased the use of prior authorization (PA), which requires physicians and other health care providers to obtain advance approval from the plan before services can be delivered to patients. While PA is a valid utilization review tool to ensure appropriate care, health care provider experience and research studies demonstrate that inappropriate use of PA causes significant patient care delays, administrative costs and workflow disruptions. The Committee directs CMS to improve Medicare beneficiary timely access to care, increase transparency, and reduce the burdens on patients and providers by providing guidance to MA plans on their use of PA. Specifically, CMS should require MA plans to selectively apply PA requirements, excluding from PA those services that align with evidence-based guidelines and have historically high PA approval rates. In addition, CMS should increase transparency by requiring MA plans to report annually to the Secretary a list of items and services that are subject to PA, the percentage of PA requests approved, and the average time for approval. Finally, the Committee encourages CMS to work with stakeholders to increase the use of electronic prior authorization.

Action Taken or To Be Taken

MA rules allow coordinated care plans to use reasonable utilization management techniques, such as prior authorization, to ensure that furnished services are both medically necessary and appropriate. However, to safeguard beneficiary access to services, MA organizations must adhere to the following rules:

- MA organizations must not require prior authorization for emergency and urgent care services and services rendered following an emergency hospital admission before a patient is medically stable.
- MA organizations must make timely and expeditious coverage decisions in accordance with time frames stated in regulations.

MA plans are also required to disclose any coverage restrictions, such as prior authorization requirements, to providers and enrollees. For example, CMS requires plans to identify the existence of any coverage restrictions in the plan's annual distribution of Evidence of Coverage documents. In addition, in order to ensure that MA plans do not restrict access to certain services, CMS has established a robust appeals process for beneficiaries enrolled in MA plans.

CMS carefully monitors enrollee access to services through plan audits, review of beneficiary appeals, and complaints from beneficiaries or other interested parties. If CMS identifies circumstances where MA plans have inappropriately denied enrollees access to medically necessary care, CMS may impose compliance or enforcement actions, which include intermediate sanctions and civil money penalties.

In addition, CMS is working with partners in the private sector to promote interoperability. In 2018, CMS began participating in the Da Vinci project, a private-sector initiative led by Health Level 7 (HL7), a standards development organization. For one of the use cases under this project – called "Coverage Requirements and Documentation Rules Discovery". CMS encourages all payers, including but not limited to MA organizations and Part D plan sponsors, to follow CMS's example and align with the Da Vinci Project's Coverage Requirements and Documentation Rules Discovery work by: (1) developing a similar lookup service; (2) populating it with their list of items/services for which prior authorization is required; and (3) populating it with the documentation rules for, at least, oxygen and CPAP. By taking this step, MA organizations and Part D plan sponsors can join CMS in helping to build an ecosystem that will allow providers to connect their EHRs or practice management systems and efficient work flows with up-to-date information on which items and services require prior authorization and what the documentation requirements are for various items and services under that patient's current plan enrollment.

Recovery Audit Program - The agreement directs CMS to conduct an internal review of their Recovery Audit program in an effort to identify inefficiencies in the current system. CMS shall include their findings in the annual report to Congress.

Action Taken or To Be Taken

Information on the effectiveness of the Recovery Audit Programs under Medicare and Medicaid is provided through CMS' annual Report to Congress on the Medicare and Medicaid Integrity Programs. The most recent report is available at: https://www.cms.gov/About-CMS/Components/CPI/Downloads/FY-2017-Medicare-and-Medicaid-Integrity-Programs-Report-to-Congress.pdf.

Risk Corridor Program - CMS is directed to provide a yearly report to the Committees detailing any changes to the receipt and transfer of payments.

Action Taken or To Be Taken

The risk corridors program concluded in the 2016 Benefit Year. The requested information is available on the CMS website at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs

Sepsis.—The Committee is concerned that sepsis and antibiotic resistant bacteria continue to be leading public health threats that are responsible for a significant number of deaths, as well as rising costs within the healthcare system. According to the most recent data, the national average compliance rate for CMS's sepsis treatment measure, known as SEP–1, is only 49 percent. The Committee urges CMS to issue a Request for Information to gather views on proposals to modernize and optimize CMS's current SEP– 1 measure. The Committee requests an update on these activities in the fiscal year 2021 Congressional Budget Justification.

Action Taken or To Be Taken

CMS agrees that ensuring proper sepsis treatment and antibiotic stewardship is crucial to protecting patients in healthcare facilities and in the community at large. As stated in CMS' Measure Inventory Tool (https://cmit.cms.gov/CMIT_public/ReportMeasure?measureRevisionId=300), a principle of sepsis care is that clinicians must rapidly treat patients with an unknown causative organism and unknown antibiotic susceptibility. Since patients with severe sepsis have little margin for error regarding antimicrobial therapy, initial treatment should be broad spectrum to cover all likely pathogens. CMS continues to work closely with the Sepsis (SEP-1) quality measure stewards and stakeholders on measure updates. Since measure inception in 2015, the stewards have made many updates to the measure to improve abstraction, reduce burden, and address concerns raised by clinicians and stakeholders. Measure updates have taken into account evolving clinical practice and current measure specifications align with the Surviving Sepsis Campaign guidelines. The SEP-1 measure is up for National Quality Forum re-endorsement next year and CMS plans to continue close collaboration with the measure stewards and stakeholders on potential updates and/or changes to the SEP-1 measure. Additionally, CMS expects to begin working on a sepsis outcome measure and has formed a Technical Expert Panel that will help inform development of this new measure

CMS shares the Committee's concern about antibiotic resistance. The consequences resulting from misuse of antibiotics are severe, leading to life-threatening infections, adverse drug events, and increasing the prevalence of drug-resistant bacteria. In recognition of the importance of proper antibiotic stewardship, on September 30, 2019, CMS finalized requirements that will ensure that all participating hospitals and critical access hospitals implement antibiotic stewardship programs following nationally recognized guidelines (84 FR 51732). Specifically, the final rule includes important requirements for the implementation of antibiotic stewardship programs as part of the Conditions of Participation for hospitals and critical access hospitals in the Medicare and Medicaid programs. We believe that these antibiotic stewardship programs will provide a critical tool for hospitals and critical access hospitals to use in the fight against the emergence of new strains of antibiotic-resistant bacteria and in the defense of our currently effective antimicrobials.

Therapeutic Foster Care - The agreement requests an update in the fiscal year 2021 Congressional Justification on the study requested in House Report 114-699.

Action Taken or To Be Taken

CMS is committed to increasing state flexibility within the Medicaid program while reducing burdens for states in order to serve the health and wellness needs of our most vulnerable populations. We are currently examining the impact of a uniform definition of therapeutic foster care services under these objectives, while remaining cognizant of the fact that states may be best-positioned to define these services.

Underperforming Healthcare Facilities - Within six months of enactment of this Act, the agreement directs CMS to provide the Committees a report on the resources the agency requires to ensure all nominees for the program become full participants, subject to the special focus facility (SFF) program's enhanced surveying and progressive enforcement standards. The agreement further directs CMS to disclose the names of nursing homes that are eligible for the SFF program, but are not officially part of SFF, on the Nursing Home Compare website.

Action Taken or To Be Taken

CMS has many levers for quality improvement in nursing homes, and the SFF program is just one. The SFF program was created in 1998 to target low-quality facilities for additional scrutiny. The SFF program focuses on nursing homes that have a track record of substandard quality of care. Although such facilities have sometimes incorporated enough improvement in the presenting problems to pass one survey, they have frequently manifested many problems on the next survey, often for many of the same problems as before. Such facilities with a "yo-yo" compliance history rarely addressed the underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.

There are 15,000 nursing homes in the country, and almost 3,000 of these have a one-star rating on their health inspections. By contrast, there are only 88 SFF program slots, and only about 400 candidates for the program. CMS regularly helps states narrow down the list of poor performers to identify nursing homes that are candidates for the program. Candidates for the SFF program have low star ratings which any consumer can easily find on the CMS Nursing Home Compare website. The methodology for identifying facilities for the SFF program is based on the same methodology used in the "health inspection" component of the Five-Star Quality Rating System on Nursing Home Compare. The list of SFF facilities and candidates for the SFF program are posted on the CMS Website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/SFFList.pdf.

Once a state selects a facility as an SFF, the State Survey Agency, on CMS's behalf, conducts a full, onsite inspection of all Medicare health and safety requirements every six months and recommends progressive enforcement (e.g., fines, denial of Medicare payment) until the nursing home either (1) graduates from the SFF program; or (2) is terminated from the Medicare and/or Medicaid program(s). The State Survey Agency will also apply progressively stronger enforcement actions in the event of continued failure to meet Medicare and/or Medicaid participation requirements. Enforcement sanctions will be of increasing severity for SFFs that do not make significant improvement.

CMS is committed to working with Congress to strengthen nursing home enforcement. This Budget requests authority to adjust the frequency of mandatory nursing home surveys so CMS can focus more of our time and resources on nursing homes that are poor performers while continuing efforts to respond to complaints. This Budget also requests $442 million for Survey and Certification, a $45 million increase from the previous year. The increased funding would enable CMS to continue to meet the statutory survey requirements while dealing with the increase in volume and severity of complaints, and rising survey costs.

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Program Management Proposed Law Summary

CMS' FY 2021 Budget includes six proposals. Each of the proposals will require legislative changes and are described in more detail below:

- **Rebase National Medicare Education Program User Fee**

  The Budget includes a proposal that allows CMS to assess an increased amount of user fees from Medicare Advantage and Part D plans to more equitably support outreach and enrollment assistance activities provided by the National Medicare Education Program.

- **Change Medicare Beneficiary Education Requirements**

  The Budget includes a proposal that provides the Secretary with increased flexibility to determine how to most efficiently and effectively communicate Medicare benefits information included in the Medicare & You Handbook with beneficiaries, including providing information through electronic means as opposed to paper copies.

- **Charge Long-Term Care Facilities Fees for Revisit Surveys**

  The Budget proposes to allow CMS to charge long-term care facilities fees for revisits required to validate correction of deficiencies identified during initial and re-certification visits or facility-reported incidents. Fees would cover associated costs necessary to perform revisit surveys. This proposal incentivizes quality of care and resident well-being.

- **Tailor the Frequency of Skilled Nursing Facility Surveys to More Efficiently Use Resources and Alleviate Burden for Top Performing Nursing Homes**

  The Budget includes a proposal that gives the Secretary authority to adjust statutorily required survey frequencies for top-performing skilled nursing facilities and reinvest resources to strengthen oversight and quality improvement for poor performing facilities.

- **Two Year Budget Authority for Survey and Certification**

  The Budget includes a proposal for two-year budget authority for the Survey and Certification Program. This proposal will enable states to more effectively plan, staff, and fund their survey agency to accomplish federally mandated survey workloads.

- **Availability of CMS Exchange User Fee**

  The Budget includes a proposal to allow user fees collected for Federal Exchange operations to be used on all federal administrative Exchange-related activities. This includes activities that CMS conducts on behalf of all Exchanges that are currently not eligible to be paid for by user fees, such as eligibility verification, issuer payment activities, Exchange quality, and associated IT.

Program Management Appropriation Summary

Proposed Law

(Dollars in Thousands)

Activity	FY 2019 Final	FY 2020 Enacted	FY 2021 Budget Request
Program Operations /1	$2,815,875	$2,824,823	$2,478,823
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$2,815,875	$2,824,823	$2,478,823
Federal Administration	$732,533	$732,533	$772,533
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$732,533	$732,533	$772,533
State Survey & Certification	$397,334	$397,334	$442,192
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$397,334	$397,334	$442,192
Research, Demonstration & Evaluation /2	$20,054	$20,054	$0
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$20,054	$20,054	$0
Discretionary Appropriation, Net	**$3,965,796**	**$3,974,744**	**$3,693,548**
Discretionary Appropriation, Proposed Law	**$0**	**$0**	**$0**
Total Appropriation, Proposed Law	**$3,965,796**	**$3,974,744**	**$3,693,548**

/1 FY 2019 reflects the use of HHS Secretary's Transfer Authority totaling $8.948 million.

/2 In FY 2021, the funding request is included within Program Operations.

Modernization of the Public-Facing Digital Services – 21st Century Integrated Digital Experience Act

On Dec. 20, 2018, President Trump signed the 21st Century Integrated Digital Experience Act (IDEA), which requires data-driven, user-centric website and digital services modernization, website consolidation, and website design consistency in all Executive Agencies. Departments across the federal landscape are beginning to implement innovative digital communications approaches to increase efficiency and create more effective relationships with their intended audiences. The American public expects instant and impactful communications – desired, trusted content available when they want it, where they want it, and in the format they want it. If the consumer is not satisfied they move on and our opportunity for impact is lost.

Modernization Efforts

In FY 2019 HHS engaged Department leadership and developed a Digital Communications Strategy that aligns with the requirements of IDEA. As the result of a comprehensive review of costs associated with website development, maintenance, and their measures of effectiveness, HHS will prioritize:

- modernization needs of websites, including providing unique digital communications services, and
- develop estimated costs for achieving performance metrics.

Over the next five years HHS will continue to implement IDEA by focusing extensively on a user-centric, Digital First approach to both external and internal communications and developing performance standards. HHS will focus on training, hiring, and tools that drive the communication culture change necessary to successfully implement IDEA.

Over the next year, HHS Agencies and Offices will work together to continue to implement IDEA and the HHS Digital Communications Strategy across all communications products and platforms.

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PROGRAM OPERATIONS

MCR9: Ensure Beneficiary Telephone Customer Service

Measure	FY	Target	Result
MCR9.1a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act*	2021	90%	October 31, 2021
	2020	90%	October 31, 2020
	2019	90%	99% (Target Exceeded)
	2018	90%	98% (Target Exceeded)
	2017	90%	98% (Target Exceeded)
	2016	90%	98% (Target Exceeded)
MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment*	2021	90%	October 31, 2021
	2020	90%	October 31, 2020
	2019	90%	94% (Target Exceeded)
	2018	90%	97% (Target Exceeded)
	2017	90%	97% (Target Exceeded)
	2016	90%	96% (Target Exceeded)
MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment*	2021	90%	October 31, 2021
	2020	90%	October 31, 2020
	2019	90%	95% (Target Exceeded)
	2018	90%	97% (Target Exceeded)
	2017	90%	97% (Target Exceeded)
	2016	90%	95% (Target Exceeded)

Measure	FY	Target	Result
MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey*	2021	90%	October 31, 2021
	2020	90%	October 31, 2020
	2019	90%	94% (Target Exceeded)
	2018	90%	94% (Target Exceeded)
	2017	90%	93% (Target Exceeded)
	2016	90%	92% (Target Exceeded)

* Prior years' targets and results for this goal can be found in previous CMS Budgets.

The Contact Center Operations (CCO) handles both beneficiary (Medicare) and consumer (Exchange) inquiries. A CMS Quality Call Monitoring process is used by the CCO to evaluate each Customer Service Representative's (CSR's) performance in responding to telephone inquiries. The CCO is responsible for evaluating and scoring each CSR's performance each month in handling telephone inquiries using the quality standards of privacy act, knowledge skills, and customer skills.

For each fiscal year, the CCO has met or exceeded the target of 90 percent for each standard. Despite exceeding targets in previous reporting years, CMS will continue to maintain the quality standards target levels at 90 percent. In order to increase contact center quality standards, contact centers would need to increase the amount of quality assurance staff responsible for monitoring and coaching. This would mean additional costs for the contractors supporting the contact center. The resources required to ensure a higher quality metric would be better allocated to the increased contacts associated with the incoming baby boomer population.

Since FY 2009, the CCO has been assessed annually by an Independent Quality Assurance (IQA) contractor. The intent of this assessment is to gather more detail on where improvements can be made in handling telephone inquiries, to better serve the calling population. There is currently a parallel effort between the CCO and the IQA contractor to assess quality through quality monitoring tools – but for separate purposes. The CCO contractor uses Quality Call Monitoring for coaching individual CSRs. Alternatively, CMS' IQA contractor uses Quality Call Monitoring to assess quality from a global perspective, as well as to identify processes and areas needing attention and make specific recommendations regarding quality improvements. Part of the IQA Plan addresses quality oversight of English and Spanish inbound and outbound telephone and written correspondence, as well as e-mail, web chat, and faxed inquiries. CMS will use the results of the IQA audits for root cause analysis and for identifying areas of improvement for training and content materials as well as any other tools currently available to CSRs. Since 2009, this performance measure has been based on survey methods designed by CMS, with questions approved by the Office of Management and Budget (OMB). The

survey measures a variety of customer service dimensions, including overall satisfaction, program knowledge, clarity, rapport, customer effort, and First Call Resolution, capturing an aggregated score of these dimensions.

MCR12: Maintain CMS' Improved Rating on Financial Statements

Measure	FY	Target	Result
MCR12: Maintain an unmodified opinion*	2021	Maintain an unmodified opinion	November 15, 2021
	2020	Maintain an unmodified opinion	November 13, 2020
	2019	Maintain an unmodified opinion	Target Met
	2018	Maintain an unmodified opinion	Target Met
	2017	Maintain an unmodified opinion	Target Met
	2016	Maintain an unmodified opinion	Target Met
	2015	Maintain an unqualified opinion	Target Met
	2014	Maintain an unqualified opinion	Target Met
	2013	Maintain an unqualified opinion	Target Met

* Prior years' targets and results for this goal can be found in previous CMS Budgets.

The Chief Financial Officers (CFO) Act of 1990 creates a framework for the federal government to focus on the integration of accounting, budget, and other financial activities under one umbrella. This is meant to reduce waste and to provide complete, reliable, timely, and consistent information to Congress on the financial status of the federal government.

CMS's annual goal is to maintain an unmodified opinion, which indicates that its financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources, and the projected future value of Medicare's social insurance programs. An independent audit firm reviews the financial operations, internal controls, and compliance with laws and regulations at CMS and its contractors.

CMS met its FY 2019 target of maintaining an unmodified opinion on four out of the six principal financial statements. During FY 2019, the auditors could not express an opinion on the CMS Statement of Social Insurance (SOSI) or the CMS Statement of Changes in Social Insurance Amounts (SCSIA). CMS has been substantially compliant with the Federal Financial Management Improvement Act (FFMIA) since FY 2010. CMS considers its financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems.* The Healthcare Integrated General Ledger Accounting System (HIGLAS) is CMS's official financial system of record used to produce its financial statements. Overall, CMS continued to improve its financial management performance in many areas, as evidenced by no material weaknesses being reported as a result of the agency's CFO audit and OMB Circular A-123 review. In addition, CMS provided a FY 2019 Federal Managers' Financial Integrity Act (FMFIA) statement of reasonable assurance

regarding the Agency’s internal controls over financial reporting for June 30 and September 30.

MCR26: Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries

Measure	CY	Target	Result
MCR26: Reduce all-cause hospital readmission rate by 1% per year from the prior year's actual rate[1]	2021	17.3%[2]	March 1, 2021 (based on CY 2019 data)
	2020	17.5%	March 1, 2020 (based on CY 2018 data)
	2019	17.4%	17.7% (Target Not Met) (based on CY 2017 data)
	2018	17.8%	17.6% (Target Exceeded) (based on CY 2016 data)
	2017	17.4%	18.0% (Target Not Met) (based on CY 2015 data)
	2016	17.4%	17.6 % (Target Not Met) (based on CY 2014 data)
	2015	17.9%	17.6% (Target Exceeded) (based on CY 2013 data)
	2014	18.3%	18.1% (Target Exceeded) (based on CY 2012 data)
	2013	18.5%	18.6% (Target Not Met) (based on CY 2011 data)
	2012	Baseline	18.7% (Baseline – based on CY 2010 data)

[1] CMS targets reduction of all-cause Medicare hospital readmissions by one percent (not to be confused with one percentage point) per year from the prior year's actual rate (if available) or the prior year's target for the time period when the prior year's actual rate is not yet known. To meet or exceed the Target, the Result must be less than or equal to the calculated Target. [2] The CY 2021 target may be adjusted based on CY 2020 result.

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. One way that the Medicare statute incentivizes hospitals to reduce preventable readmissions is through the Hospital Readmissions Reduction Program (HRRP). Established by Congress beginning in FY 2013, the HRRP reduces a statutorily defined portion of Medicare's payment amounts for certain potentially preventable Medicare inpatient hospital readmissions covering three conditions: Acute Myocardial Infarction, Pneumonia, and Congestive Heart Failure. For FY 2015 and beyond, two additional readmission measures were added to the program: (1) Chronic Obstructive Pulmonary Disease and (2) Total Hip Arthroplasty and Total Knee Arthroplasty. For FY 2017 and beyond, CMS established an additional measure for patients readmitted following Coronary Artery Bypass Graft Surgery, and CMS refined the Pneumonia readmission measure cohort. Additionally, the 21st Century Cures Act requires CMS to assess a hospital's performance relative to other hospitals with a similar proportion

of patients who are dually eligible for Medicare and full-benefit Medicaid beginning in FY 2019.

In addition to the HRRP, CMS leverages efforts of other programs to reduce hospital readmissions. Among these are the Quality Improvement Network – Quality Improvement Organizations that work to reduce preventable complications during a transition from one care setting to another, which includes partnership with the Community-Based Care Transitions Program and Quality Improvement Organizations. CMS' efforts to reduce readmissions also extend to Accountable Care Organizations, which must report on and meet targets for quality measures if they wish to receive incentives under the Medicare Fee-for-Service Shared Savings Program, and to CMS Innovation Center's Bundled Payments for Care Improvement Advanced Model, which includes a readmissions measure to encourage hospitals and their care teams to collaborate and ensure that they provide appropriate discharge planning, instructions, and follow up care to patients to help reduce the risk of readmission.

CMS did not meet its target for CY 2019 following one year, CY 2018, where its target was exceeded. This followed two years, CY 2017 and CY 2016, where the targets were not met. Although the readmission rate increased slightly, overall the readmission rates appear to be relatively constant since CY 2015 following a historical pattern of slight reductions (the slight increase in CY 2017 appears to be an anomaly). It is unclear whether this trend will continue or whether rates will increase or decrease further. In light of these results, CMS has set slightly less aggressive targets for FY 2020 and FY 2021. CMS set the 2020 target at 17.5 percent and the 2021 target at 17.3 percent based on the CY 2019 result, but the CY 2021 target may be adjusted based on CY 2020 result. CMS will continue to monitor the data and will report on the CY 2020 target in the first half of 2020.

MCR36: Shift Medicare Health Care Payments from Volume to Value

Measure	CY	Target	Result
MCR36: Increase the percentage of Traditional Medicare health care dollars tied to Alternative Payment Models (APMs) incorporating downside risk	2021	40%	December 15, 2022
	2020	30%	December 15, 2021
Baseline: CY 2019 Developmental	2019	Baseline (Develop-mental)	December 15, 2020

The Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI), identifies, tests, evaluates, and expands, as appropriate, innovative payment and service delivery models. These innovative payment and service delivery models can reduce program expenditures for Medicare, Medicaid, and the Children's Health Insurance Program, while improving or preserving beneficiary health and quality of care. Under this authority, CMS is testing a variety of Alternative Payment Models (APMs) that create new incentives for clinicians to deliver better care at a lower cost and reward quality and efficiency of care.

To achieve the goals of better care, smarter spending, and healthier people, the United States (U.S.) health care system must substantially reform its payment structure to incentivize quality health outcomes and pay for value over volume. However, to change the entire U.S. health care system from a volume incentivized system to a value-based system, commercial, Medicare Advantage, and Medicaid payers also need to adopt the same payment reform goals as Medicare. For this reason, HHS publically announced in 2015 the aggressive goal to tie 30% of Traditional Medicare payments to APMs linked to quality and value by 2016 and 50% by 2018, while simultaneously establishing the Health Care Payment Learning and Action Network (LAN) to align the rest of the U.S. heath care system with HHS' payment goals and jointly measure progress towards those goals. The LAN's nationwide measurement effort that developed in response has been highly successful—evolving to incorporate data from a large sample of payers (including Traditional Medicare) that represent nearly 80% of covered Americans, and now serving as the most comprehensive snapshot available for measuring progress on payment reform. In 2018 and 2019, the LAN began reporting payment data by line of business—Commercial, Medicaid, Medicare Advantage, and Traditional Medicare.[1]

APMs and payment reforms that increasingly tie Fee-for-Service (FFS) payments to value are currently moving the health care system in the right direction. Nonetheless, current rates of health care spending are unsustainable, and there is an urgent need to substantially transform the way health care is paid for and delivered. Downside risk APMs

[1] The LAN's APM measurement results and methodology use for CY 2015, 2016, 2017, 2018 and 2019 can be found at: https://hcp-lan.org/apm-measurement-effort/

hold promise for driving this fundamental change, because they promote incentives and flexibility to innovate and improve care delivery. In order to continue the advancement of value-based care, CMS aims to increase the adoption of downside risk APMs, which include the potential for participants to either gain *or lose* money based on their performance, givinggiving them direct financial accountability for beneficiaries' costs and quality of care.[2] Unlike the prior APM adoption performance goal, this updated goal does not includeeinclude upside-only models.

Medicare is leading the way by publicly announcing, tracking, and reporting payments tied to APMs that are taking on downside risk, while working through the LAN to ensure that its large group of payers, providers, purchasers, patients, product manufacturers, and policymakers across the U.S. also adopt aligned goals to move towards downside risk APMs. To that end, at the annual LAN Summit on October 24, 2019, Secretary Azar and the LAN jointly announced a new goal for commercial, Medicare Advantage, Medicaid, and Traditional Medicare to accelerate the percentage of U.S. health care payments tied to quality and value in each of those market segments through the adoption of downside risk APMs.[3] Traditional Medicare set targets in that announcement to increase downside APM adoption to 30% by 2020, 40% by 2021, and 50% by 2022. These targets have been incorporated into this updated APM goal. The final CY 2019 baseline for this new downside risk APM goal will become available in the late Fall of 2020 and will be reported at the annual LAN Summit if available. in the FY 2022 CMS CJ

[2] Medicare downside risk APMs may also qualify as advanced APMs as required by the Quality Payment Program as long as they meet the other requirements of that program.
[3] A livestream of this joint announcement can be found at: https://www.lansummit.org/

MCR37: Increase Patient Choice in Dialysis Treatment

Measure	CY	Target	Result
MCR37: Increase the percentage of new dialysis patients who choose home dialysis modalities	2021	18.87%	Oct 31, 2022
	2020	18.30%	Oct 31, 2021
	2019	Historical Actual	Oct 31, 2020
	2018	Baseline	17.15%

This measure monitors the number of new End-Stage Renal Disease (ESRD) patients that start dialysis with a home modality within 180 days of initial dialysis. The President's Executive Order (EO) on Advancing American Kidney Health (AAKH) focuses on increased patient choice to use of home dialysis. The U.S. Department of Health and Human Services (HHS) has a goal of 80 percent of new ESRD patients either receiving dialysis at home or receiving a a transplant by 2025. This measure will track our progress towards that goal and supports the HHS Agency Priority Goal (APG) on Kidney Care and strategies for Advancing American Kidney Health.

Studies have shown that use of home dialysis results in better or equal clinical outcomes and reduced hospitalization as compared to In-Center Hemodialysis (ICHD). Patients who choose home dialysis for treatment report more energy, flexible treatment schedules, fewer diet and fluid restrictions and more freedom to travel. Despite these reported benefits, in 2018 home dialysis was underutilized in the U.S. with approximately 8 percent of the dialysis patients undergoing renal replacement therapy at home versus approximately 92 percent being treated with in-center hemodialysis.[4] Home dialysis modalities include:

- Peritoneal Dialysis (PD): This treatment uses the patients' peritoneum and a cleansing fluid to filter waste and extra fluid utilizing a catheter that is placed in the belly. It can be done most anywhere, including home, school, work and while traveling. A patient can complete this treatment without any assistance.

- Home Hemodialysis (HHD): Similar to in-center hemodialysis, HHD cleans a patients' blood utilizing a vascular access site (e.g., arteriovenous fistula, arteriovenous graft), dialysis machine and an artificial kidney (i.e., filter). The HHD machines are smaller and portable, allowing for patients to dialyze at home or when traveling. Most often a care partner is required for treatment, but some new technology allows for patients to dialyze unaided.

[4] https://esrdncc.org/en/resources/professionals/about-the-networks/summary-annual-reports-2/

Data from the U.S. Renal Data System (USRDS) indicate that annual cost of home dialysis is substantially less than in-center dialysis for qualified patients. The annual cost of in-center therapy for all modalities is approximately $78,049 a year versus approximately $66,751 for therapy at home—a difference of $11,298 per year.

There are a number of barriers related to increasing the use of home dialysis. Key examples include: lack of patient and provider education about home dialysis modalities, provider hesitancy to refer patients due to lack of familiarity, and lack of psychosocial and financial support for patients and care partners.[5] Current ESRD Network projects in conjunction with other Network of Quality Improvement & Innovation Contractors (NQIIC) work in tandem to mitigate these challenges.

As a result of the ongoing work of the ESRD Network Program, specifically the 2018 home dialysis quality improvement activity, in which Networks partnered with 30 percent of dialysis facilities nationwide, 5,252 ESRD patients transitioned from ICHD to a home dialysis modality representing an approximate cost savings of $59 million. CMS continues to promote increased use of home dialysis modalities through the ESRD Networks' Quality Improvement Activity projects and other collaborative activities with the renal community.

To calculate this measure, home dialysis is defined as either peritoneal dialysis or home hemodialysis. The admission and treatment records data collected in CROWNWeb is used as the data collection source for dialysis facilities. Other aligned CMS efforts around home dialysis include work on the Kidney Care Choices (KCC) Model and the ESRD Treatment Choices (ETC) Model.

[5] Chan, Christopher T. et al. Exploring Barriers and Potential Solutions in Home Dialysis: An NKF-KDOQI Conference Outcomes Report. American Journal of Kidney Diseases, Volume 73, Issue 3, 363 - 371

MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees

Measure	CY	Target	Result
MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees Baseline 2012: 92.7[1] readmissions per 1,000 Beneficiaries	2021	0.25% Reduction From 2020 Actual	April 30, 2023
	2020	0.5% Reduction From 2019 Actual	April 30, 2022
	2019	1% Reduction From 2018 Actual	April 30, 2021
	2018	1% Reduction From 2017 Actual	April 30, 2020
	2017	Historical Actual	84.5 per 1000 (0.8% above 2016 actual)
	2016	Historical Actual	83.7 per 1,000 (0.4% below 2015 actual)
	2015	Historical Actual	84.0 per 1,000 (0.8% above 2014 actual)
	2014	Historical Actual	83.4 per 1,000 (2.7% below 2013 actual)
	2013	Historical Actual	85.7 per 1,000 (7.5% below 2012 baseline)

[1] The methodology for this goal was updated in 2017 to reflect changes in the Yale readmissions measure used in Medicare's Hospital Readmissions Reduction Program (HRRP). This is the measure upon which this goal was developed. As a result of the revised methodology that eliminated the old data coding, CMS re-calculated the prior years' reports (including the 2012 baseline), since they were based on outdated Yale measure specifications. The new calculation ensures consistent methodology across all years.

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. Discharge from a hospital is a critical transition point in a patient's care; incomplete handoffs at discharge can lead to adverse events for patients and avoidable readmissions. Hospital readmissions may indicate poor care or missed opportunities to better coordinate care, and may result in unnecessary costs.

While many studies have pointed to opportunities for improving hospital readmission rates, the rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees) is often higher than for Medicare beneficiaries overall. In 2018, an estimated 12.2 million beneficiaries were dually eligible for Medicare and Medicaid.

Compared to non-dually eligible Medicare beneficiaries, dually eligible individuals have higher rates of chronic and co-morbid conditions and higher rates of institutionalization, in addition to challenges posed by low socioeconomic status. As a result, CMS seeks to assess the impact of interventions on this sub-population.

Numerous CMS initiatives help promote safer care transitions and reduce readmissions. Data regarding a sharp decline in potentially avoidable hospitalizations (including readmissions) in the Nursing Facility Initiative (NFI) can be found in the CMS blog post: http://wayback.archiveit.org/2744/20170118123821/https://blog.cms.gov/2017/01/17/data-brief-sharp-reduction-inavoidable-hospitalizations-among-long-term-care-facility-residents/; and the Year Four Evaluation of NFI can be found here: https://innovation.cms.gov/Files/reports/irahnfrfinalyrfourevalrpt.pdf.

CMS focuses exclusively on dually eligible individuals in the *Financial Alignment Initiative*, through which CMS partners with health plans and state Medicaid agencies to test models for integrated, coordinated care for this population, and the *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents*. This work is in addition to the many other efforts and initiatives, including the Hospital Readmission Reduction Program, and systemic efforts to reduce readmissions through the Partnership for Patients, as well as the efforts to align care with quality through Accountable Care Organizations, bundled payment models, and other delivery system reforms.

This measure is calculated using the number of readmissions per 1,000 eligible beneficiaries. Eligible beneficiaries are dually eligible individuals of any age.

Based on national trends (https://www.hcup-us.ahrq.gov/reports/statbriefs/sb248-HospitalReadmissions-2010-2016.pdf) reflecting a slowing in readmissions reductions for all Medicare beneficiaries (after a number of years of larger declines), CMS has selected a more modest target reduction rate for CY 2021 of 0.25 percent.

MMB3: Support Integrated Care for Medicare-Medicaid Dually Eligible Individuals

Measure	FY	Target	Result
MMB3: Number of full-benefit dually eligible individuals in Medicare-Medicaid integrated care nationally Baseline: 832,494 (FY 2018)	2021	Contextual Measure	Nov 30, 2021
	2020	Contextual Measure	Nov 30, 2020
	2019	Contextual Measure	1,006,927

Over 12 million Americans are concurrently enrolled in both the Medicare and Medicaid programs. Overall, dually eligible individuals have a higher prevalence of many health conditions than their Medicare-only and Medicaid-only peers. These individuals must navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and drugs, and Medicaid for coverage of long-term services and supports (LTSS), certain behavioral health services, and for help with Medicare premiums and cost sharing.

A lack of alignment and cohesiveness between the Medicare and Medicaid programs can lead to fragmented and episodic care for dually eligible individuals and misaligned incentives for both payers and providers. This may result in reduced quality and increased costs to both programs and to enrollees. Dually eligible individuals could benefit from more integrated systems of care that meet all of their needs – primary, acute, long-term, behavioral, and social – in a high quality, cost-effective manner. Better alignment of the administrative, regulatory, statutory, and financial aspects of these two programs holds promise for improving the quality and cost of care for this complex population.

In recent years, CMS has partnered with states to develop innovative, integrated care and financing approaches. CMS has focused on initiatives to better integrate and strengthen access to care for dually eligible individuals and to eliminate unnecessary cost shifting between the Medicare and Medicaid programs. There are a range of approaches to integrating Medicare and Medicaid benefits and/or financing, including through Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), the Programs of All-inclusive Care for the Elderly (PACE), and integrated care models and demonstrations such as the Medicare-Medicaid Financial Alignment Initiative. Since 2011, the number of full-benefit dually eligible individuals in integrated care and/or financing models has seen, a more than four-fold increase.[6] In FY 2018, there were 832,494 eligible individuals and 1,006,927 in FY 2019, a 21 percent increase. However, in 2018, fewer than 10 percent of full benefit

[6] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FY-2018-Report-to-Congress.pdf

dually eligible individuals were enrolled in integrated care programs. Promoting integrated care, and integrated care options, is a high priority for CMS.

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MEDICARE SURVEY & CERTIFICATION PROGRAM

MSC5: Decrease the Percentage of Long-stay Nursing Home Residents Receiving an Antipsychotic Medication

Measure	CY	Target	Result
MSC5: Decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication	2021	15.3%	April 30, 2022
	2020	15.4%	April 30, 2021
	2019	15.5%	April 30, 2020
	2018	16.0%	14.6% (Target Exceeded)
	2017	16.0%	15.4% (Target Exceeded)
	2016	16.7%	16.7% (Target Met)
	2015	17.9%	17.1% (Target Exceeded)
	2014	19.1%	19.1% (Target Met)
	2013	20.3%	20.3% (Target Met)
	2012	Historical Actual	19.8%
	2011	Baseline – 23.87% (4th Q)	Last Quarter of Pre-Intervention Period

The purpose of this performance measure is to decrease the use of antipsychotic medications in nursing homes with an emphasis on improving dementia care. These medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia.

In 2012, CMS began a nationwide initiative - the *Partnership to Improve Dementia Care in Nursing Homes* – to improve dementia care and reduce the use of antipsychotic medications. CMS staff works with partners, including state coalitions, provider associations, nursing home resident advocates, and stakeholders, to decrease the use of these drugs. Some of this work includes developing and conducting trainings for nursing home providers, surveyors, and consumers; conducting research; raising public awareness; using regulatory oversight; improving surveyor guidance; conducting focused dementia care surveys in selected states; and public reporting, to increase transparency. CMS hopes to enhance person-centered care for all nursing home residents, particularly those with dementia-related behaviors.

A number of evidence-based, non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the National Partnership to Improve Dementia Care. These have been incorporated into clinical practice guidelines and various tools and resources and are now posted on the Advancing Excellence website (in the public domain) at www.nhqualitycampaign.org. State Coalitions are reaching out to

providers in every state and encouraging the use of these resources, as well as Hand in Hand, the training for nursing home staff developed by CMS. A number of meta-analyses have reviewed the use of non-pharmacological approaches to behaviors in people with dementia. Studies have shown that these interventions may be effective in reducing behaviors associated with dementia that may be distressing to residents or families.[7]

Person-centered care is an approach that focuses on residents as individuals, and supports caregivers, working most closely with them. It utilizes a continual process of listening, testing new approaches, and changing routines and organizational strategies in an effort to individualize and de-institutionalize the care environment. Person-centered care is the central theme of the Hand in Hand training.

In July 2012, CMS began posting on the Nursing Home Compare website, quality measures of antipsychotic use in long-stay and short-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. In 2015, CMS added the quality measures to the Five-Star Quality Rating System on the website.

For this goal, CMS reports the prevalence of antipsychotic use in the last three months of the fiscal year. The numerator consists of long-stay residents receiving an antipsychotic medication on the most recent assessment. The denominator is all long-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. Residents are considered to be long-stay residents if they have resided in the nursing home for 101 or more days. The baseline number reflects the prevalence of use in the last quarter of the calendar year 2011. It was selected because it was the last quarter in the pre-intervention period.

In 2011, 23.9 percent of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 36.6 percent to a national prevalence of 15.1 percent in 2017. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 40 percent. CMS continues to have quarterly national calls with the public on aspects of good dementia care and the use of non-pharmacological approaches. CMS is conducting focused dementia care surveys on facilities that continue to have high rates of antipsychotic use, and has modified the regulations limiting the use of antipsychotic medications on an as-needed basis.

[7] Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic Management of Behavioral Symptoms in Dementia. JAMA, November 21, 2012; 308(19): 2020-2029.

MSC6: Percentage of Hospice Facilities that Have Been Surveyed within 36 Months

Measure	FY	Target	Result
MSC6.2: Percentage of facilities that are surveyed within the required 36 month timeframe	2021	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2022
	2020	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2021
	2019	98% of hospice facilities are surveyed within the required 36 month timeframe	May 31, 2020
	2018	95% of hospice facilities are surveyed within the required 36 month timeframe	96.5% (Target Exceeded)

A hospice is a public agency or private organization that is primarily engaged in providing care to terminally ill individuals. Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family/caregivers. The emphasis of the hospice program is on keeping the hospice patient at home with family and friends as long as possible.

Although some hospices are part of a hospital, nursing home, or home health agency, all hospices must meet specific federal requirements and be separately certified and approved for Medicare participation. There are approximately 4,000 Medicare certified hospice agencies in the U.S providing care to over 1 million Medicare beneficiaries annually. CMS is working on including the data for nursing homes and home health agencies.

The Social Security Act mandates the establishment of minimum health and safety standards for all participating hospice providers. These standards are further defined in the Medicare Conditions of Participation (COPs), which establish the minimum requirements that a hospice agency must meet in order to participate in Medicare. State Survey Agencies (SAs), under agreements between the state and CMS, evaluate hospice compliance through the survey and certification process.

The *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act)

mandates the frequency of hospice recertification surveys to be not less frequently than once every 36 months. Prior to the IMPACT Act, CMS did not have a legislative or regulatory standard for the frequency of hospice recertification surveys. Annual targets for these surveys were established by agency policy based on available resources each year and had been every 72 months. In addition to mandating a 36 month frequency of hospice recertification surveys, the IMPACT Act provides funding to support CMS in meeting this requirement. The shorter duration for hospice recertification surveys mandated by the IMPACT Act will ensure hospice providers are more frequently assessed against the minimum requirements for quality of care, providing greater oversight of these providers by CMS.

The purpose of this measure is to ensure that the new statutory requirement for the hospice survey interval is met nationally. Although the CMS target is 100 percent compliance with the statutory requirement, the stated measure represents a realistic expectation, considering the resources required to achieve the new survey interval. The data to confirm compliance with the requirements of the Act was not available until September 30, 2018. This data delay is a result of necessary follow up survey activity and data entry into the Automated Survey Processing Environment system. A post-September 30, 2018 review of the data indicates that as of April 18, 2018, 96.5 percent of all certified hospice agencies were surveyed in compliance with the requirements of the Impact Act.

To comply with the IMPACT Act and to ensure that states have plans in place to maintain compliance going forward, CMS worked through the CMS Regional Offices (ROs) to identify all hospice providers that required surveys by April 6, 2018.

The targets set beginning in FY 2018 are concise and clearly indicative of whether or not the work, as required by the Act, is being accomplished. CMS believes that the goal is responsive to the IMPACT Act requirement that all hospice agencies nationwide be surveyed every 36 months.

MSC7: Improve Staffing Reports to Support Better Outcomes for Residents of Long Term Care (LTC) facilities

Measure	FY	Target	Result
MSC7: Percentage of LTC facilities submitting complete staffing data through the Payroll-Based Journal (PBJ)*	2021	96.9%	December 31, 2021
	2020	95.8%	December 31, 2020
	2019	95.6%	96.7% (Target Exceeded)
	2018	Baseline: 95.2%	December 31, 2018

*Defined as the percentage of providers whose data meet the criteria to be included in the public use file.

This measure aims to improve CMS' ability to publically report information about the staffing in long-term care (LTC) facilities, and ultimately improve care. Staffing levels, turnover, and tenure can have a significant impact on the quality of care provided by LTC facilities. This information is also very important to consumers when selecting or evaluating a LTC facility.

As of July 1, 2016, LTC providers are required to electronically submit staffing data that is auditable back to payrolls and other verifiable information in accordance with 42 Code of Federal Regulations (CFR) §483.70(q) under current law. Receiving complete staffing data from providers is essential in order to calculate and publically report accurate staffing measures, which is the primary intent of the new program.

To publish accurate information, it is critical for CMS to obtain complete data from providers, which this measure seeks to address. In April 2018, CMS began using this data to calculate staffing measures and star ratings as part of the *Five Star Quality Rating System*. Stakeholders and LTC facilities use the published information to identify targets for staffing that lead to better outcomes for residents.

To incentivize improvement, CMS adjusts how a provider is reported on Nursing Home Compare and in the Nursing Home Five Star Quality Rating System (e.g., suppress or reduce ratings). This has proven to be an effective method to improve reporting in the past. Also, CMS is conducting audits of the data submitted by providers, and will use the results of those audits to evaluate other actions that may be needed to improve the data submitted.

Baseline data for FY 2017 indicated 90.3 percent (14,162) of facilities submitted staffing data. CMS notes that this is a new program, and therefore difficult to predict the trajectory of performance. CMS will adjust the targets (lower or higher) as needed to ensure realistic and appropriate goals. Results will be calculated after the end of the first quarter for each fiscal year. For FY 2019, 96.7 percent of facilities submitted staffing data, exceeding the target of 95.6 percent. CMS believes this positive result is attributed to actions CMS has taken to rapidly improve reporting, such as suppressing or downgrading facilities' star

ratings if their data is not reported or inaccurate. Due to this result, CMS has increased the targets for FY 2020 and 2021 slightly because the trend for improvement decreased the second half of FY 2019 and the percent of providers reporting may be nearing a threshold of a maximum achievable level (i.e., ceiling).

MEDICAID

MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality initiatives

Measure	FY	Target	Result
MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives	2021	Work with States to ensure that 90% of States report on at least twelve quality measures in the CHIPRA children's core set of quality measures	March 31, 2022
	2020	Work with States to ensure that 90% of States report on at least twelve quality measures in the CHIPRA children's core set of quality measures	March 31, 2021
	2019	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	March 31, 2020
	2018	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	86% of States reported on at least eleven quality measures (Target Not Met)
	2017	Work with States to ensure that 90% of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures	88.2% of States reported on at least eleven quality measures (Target Not Met)
	2016	Work with States to ensure that 90% of States report on at least ten quality measures in the CHIPRA children's core set of quality measures	86% of States reported on at least ten quality measure (Target Not Met)
	2015	Work with States to ensure that 90% of States report on at least nine quality measures in the CHIPRA children's core set of quality measures	88% of States reported on at least nine quality measure (Target Not Met)

Measure	FY	Target	Result
	2014	Work with States to ensure that 90% of States report on at least eight quality measures in the CHIPRA children's cores set of quality measures	88% of States reported on at least eight quality measure (Target Not Met)
	2013	Work with States to ensure that 85% of States report on at least seven quality measures in the CHIPRA children's core set of quality measures.	88% of States reported on at least seven quality measure (Target Exceeded)
	2012	Work with States to ensure that 80% of States report on at least five quality measures in the CHIPRA children's core set of quality measures.	92% of States reported on at least five quality measure (Target Exceeded)
	2011	Work with States to ensure that 70% of States report on at least one quality measures in the CHIPRA children's core set of quality measures.	84% of States reported on at least one quality measure (Target Exceeded)

The purpose of this measure is to improve the quality of children's health care across Medicaid and CHIP.

The target for the child core set was nearly met in 2017. In FFY 2017, the Human Papilloma Virus (HPV) measure was included in the immunizations for adolescents (IMA) measure for the first time by the measure steward. Previously it was reported separately. This change lowered the counts of measures each state reported. We believe that because of this change, we missed the GPRA target in 2017 as well as 2018. CMS will continue to work with states to reach the goal of 90 percent of states reporting on at least eleven quality measures through FY 2019, with a new target in FY 2021 for 90 percent of states reporting on at least twelve quality measures.

Section 1139A of the Social Security Act establishes a national pediatric quality measures program. The first step in the development of this program was the publication of an initial core set (Child Core Set) of 24 children's quality measures in 2010. The 2019 Child Core Set contains 26 measures. While the use of the Child Core Set is voluntary for states until FY 2024, CMS encourages all states to use and report on the Child Core Set to collect data that will lead to improved health outcomes and enhance the accuracy and applicability of the pediatric quality measures program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for children in Medicaid and CHIP.

A State Health Official Letter (SHO) (#11-001) was released on February 14, 2011 to provide additional guidance on the Child Core Set and the process for voluntary reporting to CMS. The SHO also describes the initial CMS and AHRQ Pediatric Quality Measures Program (PQMP) developed measures that can be used to improve the Child Core Set. Thus far, the PQMP Centers of Excellence (COE) have developed 22 measures that have received National Quality Forum (NQF) measure endorsement. The current PQMP program (begun in 2016) is funding six grantees to further develop work on the feasibility and usability of PQMP measures by testing different measurement levels and quality improvement approaches to support adoption and use of these measures. Grantees are working closely with key stakeholders including state Medicaid agencies to build evidence and address the obstacles to state reporting.

Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas included in-person interactive sessions on the core measures related to data collection, reporting, and quality improvement. CMS also annually releases an updated Child Core Set Technical Specifications and Guidance for Reporting Manual, which contains technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs.

CMS will continue to work with its Technical Assistance/Analytic Support (TA/AS) contracting team to provide states with specific clarifications on measurement collection questions, hold all-state webinars as well as one-on-one calls with states around specific measurement challenges, and publish technical assistance briefs designed to provide states with guidance on measurement collection and reporting.

By using a multi-pronged approach to providing Technical Assistance (TA), CMS targets States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report them. Further, as the TA/Analytic Support program continues to mature, CMS is also expanding the scope of the TA to help states understand how to use the data they collect to drive quality improvement at the state and programmatic levels.

The CHIPRA Quality Demonstration initiative concluded in 2016, and funding to improve state efforts in core measure data collection and reporting under that grant is no longer available. Additionally, as measures are retired from the CMS Child Core Set (which states have become accustomed to reporting), and new measures are added requiring new data collection and reporting efforts, CMS recognizes that states may choose to report on a lower number of measures without continued grant funding.

CMS also anticipates that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures. It is significant to note that the Bipartisan Budget Act of 2018 (P.L. 115-123), also referred to as the ACCESS Act, requires state reporting on Child Core Set measures starting in 2024. This new requirement will likely result in an uptick in child core set reporting by states.

Findings from state reporting on the Child Core Set are published annually and available on the Children's Health Care Quality Measures webpage

(www.medicaid.gov/medicaid/qualityof-care/performance-measurement/child-core-set/index.html) of Medicaid.gov and on https://data.medicaid.gov.

CMS continues to partner with the Office of the National Coordinator and other stakeholders to address opportunities for use of electronic quality measures for potential inclusion in future annual updates to child core measures collected through EHRs.

MCD7: Improve Access to and Utilization of Oral Health Care Services for Children Covered by Medicaid and Medicaid Expansion CHIP Programs

Measure	FY	Target	Result
MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid and Medicaid expansion Children's Health Insurance Programs (CHIP), who receive any preventive dental service* National Baseline (2011) is 43%.	2021	+8 percentage points over 2011 baseline	October 15, 2022
	2020	+7 percentage points over 2011 baseline	October 15, 2021
	2019	+6 percentage points over 2011 baseline	October 15, 2020
	2018	+5 percentage points over 2011 baseline	51% (Target Exceeded)
	2017	+4 percentage points over 2011 baseline	51% (Target Exceeded)
	2016	+3 percentage points over 2011 baseline	48% (Target Exceeded)
	2015	+5 percentage points over 2011 baseline	47% (Target Not Met)
	2014	+6 percentage points over 2011 baseline	45% (Target Not Met)
	2013	+4 percentage points over 2011 baseline	44% (Target Not Met)

* Prior years' targets and results for this goal can be found in previous CMS Budgets

CMS exceeded the FY 2018 goal with 51% of children ages 0-20 years receiving a preventive dental or oral health service by a dental or other licensed professional. This is roughly the same as FY 2017, and an eight percentage point increase over the baseline year of FY 2011.

States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid and Medicaid expansion CHIP programs. Between FY 2007 and FY 2018, 38 states achieved at least a ten percentage point increase in the proportion of enrolled children, ages 1-20, who received a preventive dental service during the reporting year. Despite this improvement, only 51 percent of all enrolled children nationally received a preventive dental or oral health service in FY 2018. CMS engaged in a vigorous fact-finding process in the late 2000s to understand the issues related to state performance on children's access to dental care. To help improve performance, from 2010 to 2015 CMS implemented the Oral Health Initiative 1.0. This initiative worked with federal and state partners, the dental and medical provider communities, children's advocates, and other stakeholders to expand the number of dental professionals participating in Medicaid and to increase the awareness of the need for dental care among beneficiaries in order to continue to improve children's access to dental care, with an emphasis on prevention.

In 2016, CMS reassessed its approach to the Oral Health Initiative (OHI) and developed a new strategy, which CMS called Oral Health Initiative 2.0. It comprises six steps and has at its core a stance of integration, both vertical and horizontal, within CMS and at the state level:

(1) Identifying elements that comprise a strong state Medicaid dental program

(2) Using performance data to prioritize which states to focus on, then conducting assessments of those states to understand which elements of a strong program are in place and which are missing

(3) Communicating the results of the assessments to state agency leaders and inviting engagement for improvement

(4) Identifying opportunities across CMCS to engage with states through existing levers such as Section 1115 demonstration renewals and State Plan Amendment reviews and approvals, and providing technical support to promote oral health's importance within broader Medicaid and CHIP program objectives (beyond dental program staff)

(5) Documenting improvement targets and strategies where appropriate, such as special terms and conditions, approval letters, etc., and, (6) Having states take action based on those agreements

Through this new approach, CMS brings more explicit leadership support and broader resources to the effort to increase use of dental services among children enrolled in Medicaid and CHIP. For example, CMS has been deeply engaged with California's Dental Transformation Initiative, which dedicates $740 million to test several strategies to improve oral health in the state's 1115 demonstration. The State reports that the proportion of children ages 1-20 who have received preventive dental services has risen from 37 percent in FY 2015 to 46 percent in FY 2018. In addition, CMS adjusted its annual goals to better reflect states' current environments and their ability to drive improvement. We are determining whether to adjust our Oral Health Initiative strategies in light of progress to date, and opportunities to engage with states for further improvement.

CMS continues to work closely with other stakeholders who engage in improvement efforts with states. For example, CMS provides technical support to the Dental Quality Alliance to support states in developing and implementing performance improvement projects, which deliver dental services through managed care contracts. CMS continues to host regular Oral Health Technical Advisory Group (OTAG) calls with state Medicaid and CHIP programs to share information on core measure data collection, reporting, and related quality improvement efforts. Recent OTAG topics includes dental quality measure development, coordinating management of oral conditions in medical and dental settings, and the intersection of oral health and substance abuse issues.

MCD8: Improve Adult Health Care Quality across Medicaid

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid	2021	Work with States to ensure that 80% of States report on at least twelve quality measures in the Adult Medicaid core set of quality measures	March 31, 2022
	2020	Work with States to ensure that 75% of States report on at least twelve quality measures in the Adult Medicaid core set of quality measures	March 31, 2021
	2019	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	March 31, 2020
	2018	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	76% (Target Exceeded)
	2017	Work with States to ensure that 75% of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures	75% (Target Met)
	2016	Work with States to ensure that 70% of States report on at least nine quality measures in the Adult Medicaid core set of quality measures	70% (Target Met)
	2015	Work with States to ensure that 70% of States report on at least seven quality measures in the Adult Medicaid core set of quality measures	73% (Target Exceeded)
	2014	Work with States to ensure that 65% of States report on at least five quality measures in the Adult Medicaid core set of quality measures	67% (Target Exceeded)
	2013	Work with States to ensure that 60% of States report on at least three quality measures in the Adult Medicaid core set of quality measures	59% (Target Not Met)

* Prior years' targets and results for this goal can be found in previous CMS Budgets

The purpose of this measure is to improve health care quality for adults across Medicaid.

The target for the adult core set has been met or exceeded since 2014. CMS will continue to work with states to ensure that 75 percent of states report on at least eleven quality measures through FY 2019, 75 percent of states reporting on at least twelve quality measures in FY 2020, and 80 percent of states reporting on at least twelve quality measures in FY 2021.

Section 1139B of the Social Security Act established a national adult quality measures program for Medicaid. The 2019 Adult Core Set contains 33 measures. While the use of the Adult Core Set is voluntary for states, CMS encourages all states to use and report on the Adult Core Set to collect data that will lead to improved health outcomes and enhance the accuracy and applicability of the adult quality measures program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid. Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas include in-person interactive sessions on the core measures related to data collection, reporting, and quality improvement. CMS also annually releases an updated Adult Core Set Technical Specifications and Guidance for Reporting Manual, which contains technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs.
CMS will continue to work with its Technical Assistance/Analytic Support (TA/AS) contracting team to provide states with specific clarifications on measurement collection questions, hold all-state webinars and one-on-one calls with states around specific measurement challenges, and publish technical assistance briefs designed to provide states with guidance on measurement collection and reporting.

By using a multi-pronged approach to providing Technical Assistance (TA), CMS targets states that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report them. Further, as the TA/Analytic Support program continues to mature, CMS is also expanding the scope of the TA to help states understand how to use the data they collect to drive quality improvement at the state and programmatic levels.

As some measures are retired from the CMS adult core set (which states have become familiar with reporting) and new measures are added requiring new data collection and reporting efforts, CMS recognizes that states may choose to report a limited number of measures because they lack dedicated funding for measure data collection and reporting. In December 2012, CMS launched the two-year Adult Quality Measure Grant initiative to support state efforts in core measure data collection and reporting, but funding under that grant is no longer available.

CMS has also anticipated that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures.

It is significant to note that the Bipartisan Budget Act of 2018 (P.L. 115-123), also referred to as the ACCESS Act, requires state reporting on Child Core Set measures starting in 2024. This new requirement will likely result in an uptick in child core set reporting by

states. It does not require mandatory reporting of the adult core set but may positively influence improved adult core set reporting. Additionally, the *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018*, requires state reporting on measures in the Behavioral Health Core Set (a subset of behavioral health measures from the Adult and Child Core Sets) starting in 2024. CMS is assessing the potential impact of these recent statutory changes as their actual impact cannot be determined until implementation.

Findings from state reporting on the Adult Core Set are published annually and available on the Adult Health Care Quality Measures webpage of Medicaid.gov (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-coreset/index.html) and on https://data.medicaid.gov.

CMS continues to partner with the Office of the National Coordinator and other stakeholders to address opportunities for use of electronic quality measures for potential inclusion in future annual updates to adult core measures collected through EHRs.

MCD9: Improve Capacity to Collect Quality and Other Performance Data for Monitoring 1115 Demonstration Programs

Measure	FY	Target	Result
MCD9.1: Improve Capacity to Collect Quality and Other Performance Data for Monitoring Payment and Service Delivery Reform 1115 Demonstration Programs.	2020	Discontinued	N/A
	2019	Requirement for states to submit the data in the reporting platform from a minimum of 10 states.	Reports from 29 states submitted (Target exceeded)
	2018	Requirement for states to submit the data in the reporting platform from a minimum of 5 states.	Reports from 10 states submitted. (Target exceeded)
	2017	Testing 1 core metric data set with a minimum of 5 states.	CMS has tested 3 core metric sets with a total of 10 states (Target Exceeded)
	2016	Release of an automated collection and reporting platform for 1115 performance metrics & related requirements for State data submission.	(Target Met)

Measure	FY	Target	Result
MCD9.2 Improve Capacity to Collect Quality and Other Performance Data for Monitoring Substance Use Disorder (SUD) 1115 Demonstrations Baseline: 0 states	2021	CMS produce SUD performance trends across time and states for at least 16 demonstrations	September 30, 2021
	2020	CMS produce SUD performance trends across time and states for at least 10 states	September 30, 2020
	2019	Require states to submit the SUD metric data in the reporting platform from a minimum of 10 states	Reports from 14 states submitted (Target exceeded)
	2018		Built new SUD-specific data collection instrument and trained states with approved 1115 SUD demonstrations on use of the instrument and system

Section 1115 of the Social Security Act (the Act) provides broad authority to the HHS Secretary to grant demonstrations to states for testing innovative reforms in Medicaid and the Children's Health Insurance Program (CHIP). These measures track the development of an automated infrastructure to support section 1115 Medicaid demonstrations, including payment and/or service delivery innovations (MCD9.1) and those focusing on comprehensive treatment for substance use disorders (SUDs) (MCD9.2).

States are using 1115 demonstration authority to achieve Medicaid reform through innovative approaches to eligibility and coverage, and alternative models of service delivery and/or financing. These reforms aim at improving the quality of their Medicaid programs and their capacity to serve more people and to find alternatives to eligibility, enrollment, and coverage, to promote health improvement and independence. CMS is making significant investments in these types of demonstrations in order to study the results on a state-based and national level. However, to accomplish these goals, CMS needed an automated system for data collection and analysis of demonstration performance metrics, analytics, or reporting to assess quality performance of demonstrations. CMS developed several sets of performance metrics for high priority 1115 demonstrations. These sets have been reviewed by Medicaid State Technical Advisory Groups (TAGs) and are being rolled-out to states working with CMS to implement applicable demonstrations. Additional improvements include the development of a monitoring report template, as well as templates for reporting these metrics. CMS is focused on improving the quality and structure of data, both quantitative and qualitative, for section 1115 demonstrations,

through a more automated process that will improve federal monitoring of demonstration progress and performance. This initiative aligns with the Medicaid and CHIP Program System (MACPro) initiative to receive more complete and timely Medicaid and CHIP related data from states to support better program oversight, administration, and program integrity.

CMS's 2019 target reflects the increasing scope of the work to incorporate the standard metric sets into more Medicaid section 1115 demonstrations, to improve CMS' capability to monitor outcomes for demonstrations that are testing similar innovative approaches. As new demonstrations are approved and existing demonstrations are renewed, CMS will work with states to incorporate the appropriate metrics into state reporting to CMS. While CMS will continue to collect and analyze quality and other performance data to monitor alternative service delivery and/or financing models in Medicaid, CMS is discontinuing the measurement of this aspect of 1115 demonstrations after FY 2019. This is due to the fact that CMS is in the process of considering its expectations for approval of such demonstrations, which will likely affect the metric set and reporting requirements.

CMS achieved its 2017 MCD9.1 target by exceeding the number of metric sets that were tested by at least ten states. CMS tested three sets, including metrics for Delivery System Reform Incentive Program demonstrations. In 2018, CMS also exceeded the number of states that were required to submit data via the Performance Metrics Database and Analytics (PMDA) system, with 10 states using the reporting platform.

CMS is shifting its focus to the opioid crisis and toward state performance in improving access to, and health outcomes related to, comprehensive treatment for people with Substance Use Disorders (SUDs) under Medicaid. CMS has introduced a more recent measure, MCD9.2, to reflect these efforts. In 2018, CMS focused on developing a metric set for the SUD demonstrations, including drafting a metric data collection template and a quarterly reporting template for qualitative information. CMS was delayed in finalizing the SUD metric specifications until September 2018. The PMDA is being adjusted to collect these data and monitoring reports, assuring internal controls. In the Spring, 2019, the SUD metrics and reporting template were approved under the Paperwork Reduction Act (PRA). CMS is providing technical assistance on these templates and metrics to States with SUD applications and approved SUD demonstrations. As of November 25, there are 27 approved SUD demonstrations. These 26 states and the District of Columbia are in various phases of understanding and adopting the SUD metrics and reporting template, and the uptake by each state has taken longer than initially expected. While states have been cooperative and CMS anticipates receiving through the PMDA its first reports using the SUD templates in the last quarter of calendar year, 14 of the 27 approved SUD demonstrations have submitted qualitative and quantitative information outside of the templates but the PMDA platform.

HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC)

MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for-Service (FFS) Program

Measure	FY	Target	Result
MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for-Service (FFS) Program*	2021	TBD**	November 15, 2021
	2020	7.15%	November 15, 2020
	2019	8.00%	7.25% (Target Exceeded)
	2018	9.40%	8.12% (Target Exceeded)
	2017	10.40%	9.51% (Target Exceeded)
	2016	11.50%	11.00% (Target Exceeded)
	2015	12.5%	12.09% (Target Exceeded)
	2014	9.9%	12.7% (Target Not Met)
	2013	8.3%	10.1% (Target Not Met)

***** Prior years' targets and results for this goal can be found in previous CMS Budgets and HHS AFRs.
** Starting in FY 2017, per OMB guidance, CMS establishes improper payment rate targets only for the next fiscal year. Therefore, while the FY 2020 target of 7.15 percent was established in the FY 2019 AFR, the FY 2021 target will be established in the FY 2020 HHS AFR.

The Medicare Fee-for-Service (FFS) improper payment rate is calculated by the Comprehensive Error Rate Testing (CERT) program and reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR) on an annual basis. Information on the Medicare FFS improper payment methodology can be found in the 2019 HHS AFR. CMS exceeded its FY 2019 target. The Medicare FFS improper payment estimate for FY 2019 is 7.25 percent, or $28.91 billion. While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors. Improper payments for Skilled Nursing Facility (SNF), Hospital Outpatient, Inpatient Rehabilitation Facility (IRF), and Home Health claims were the major contributing factors to the FY 2019 Medicare FFS improper payment rate. The FY 2019 improper payment rate represented a significant decrease from the FY 2018 improper payment estimate of 8.12 percent, or $31.62 billion. This reduction was primarily driven by a reduction in improper payments for Home Health and IRF claims over that 1-year period.

SNF Claims: Insufficient documentation continues to be the major error reason for SNF claims. The SNF claims improper payment rate increased from 6.55 percent in FY 2018 to 8.54 percent in FY 2019. The primary reason for the errors was missing or insufficient

certification/ recertification statements. Medicare coverage of SNF services requires certification and recertification for these services (42 CFR §424.20).

Hospital Outpatient Claims: Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment rate for hospital outpatient claims increased from 3.25 percent in FY 2018 to 4.37 percent in FY 2019. The primary reason for the errors was that the order (or the intent to order for certain services) or medical necessity documentation was missing or insufficient (42 U.S.C. §1395y, 42 CFR §410.32).

IRF Claims: Medical necessity (i.e., services billed were not medically necessary) continues to be the major error contributor for IRF claims. The IRF claims improper payment rate decreased from 41.55 percent in FY 2018 to 34.87 percent in FY 2019. The primary reason for these errors was that the IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires a reasonable expectation that the patient meets all coverage criteria at the time of IRF admission (42 CFR §412.622(a)(3)).

Home Health Claims: Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 17.61 percent in FY 2018 to 12.15 percent in FY 2019. The primary reason for the errors was insufficient or missing documentation to support the certification of home health eligibility requirements. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR §424.22).

CMS uses data from the CERT program and other sources of information to develop various corrective actions for the purpose of reducing improper payments. CMS has developed a number of preventive and detective measures for specific service areas with high improper payment rates, including SNF, hospital outpatient, IRF and home health claims. CMS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper payment rate. Detailed information on corrective actions can be found in the 2019 HHS AFR.

MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program

Measure	FY	Target	Result
MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program*	2021	TBD	November 15, 2021
	2020	7.77% (target in FY 2019 AFR)	November 15, 2020
	2019	7.90% (target in FY 2018 AFR)	7.87% (Target Exceeded)
	2018	8.08% (target in FY 2017 AFR)	8.10%** (Target Met)
	2017	9.50% (target in FY 2016 AFR)	8.31% (Target Exceeded)
	2016	9.14% (target in FY 2015 AFR)	9.99% (Target Not Met)
	2015	8.5% (target in FY 2013 AFR)	9.5% (Target Not Met)
	2014	9.0% (target in FY 2013 AFR)	9.0% (Target Met)
	2013	10.9% (target in FY 2012 AFR)	9.5% (Target Exceeded)

***** Prior years' targets and results for this goal can be found in previous CMS Budgets and HHS AFRs.

** CMS uses Improper Payments Elimination and Reduction Act (IPERA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance on IPERA, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

In FY 2019, CMS met its Part C Medicare Advantage (MA) error rate target of 7.90 percent, reporting an actual improper payment estimate of 7.87 percent**, or $16.73 billion. The submission of more accurate diagnoses by Medicare Advantage organizations (MAOs) for payment primarily drove the decrease from the prior year's estimate of 8.10 percent.

The FY 2020 target is 7.77 percent. The FY 2021 target will be established in the FY 2020 Agency Financial Report (AFR); per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year. The FY 2019 target was met.

The Part C program payment error estimate reflects the extent to which MAO-submitted diagnoses for a national sample of enrollees are substantiated by medical records. Validation of diagnoses in medical records for sampled beneficiaries is performed during CMS' annual Medical Record Review process, where medical records are reviewed by two separate coding entities in the process of confirming discrepancies between the diagnoses submitted to CMS and the medical record. To calculate the Part C program's error estimate, the dollars in error are divided by the overall Part C payments for the year being measured.

CMS has implemented three key initiatives, described below, to improve payment accuracy in the Part C program:

Contract-Level Audits: Contract-level Risk Adjustment Data Validation (RADV) audits are CMS' primary corrective action to recoup overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by MAOs for risk adjusted payment. CMS expects payment recovery will have a sentinel effect on risk adjustment data quality submitted by plans for payment because contract-level RADV audits increase the incentive for MAOs to submit valid and accurate diagnosis information. Contract-level RADV audits also encourage MAOs to self-identify, report, and return overpayments. CMS completed payment recovery for the 2007 pilot audits, totaling $13.7 million recovered, in FYs 2012 through 2014. CMS completed several stages of the contract-level RADV audits for payment years 2011 through 2013. In April 2019, CMS launched the payment year 2014 RADV audit and held a training webinar for MAOs selected for audits to prepare the audited MAOs for RADV audits. The payment year 2014 RADV audit is currently underway and is expected to conclude in late FY 2020. CMS launched the payment year 2015 RADV audit in late FY 2019.

Overpayment Recoveries Related to Regulatory Provisions: As required by the Social Security Act, CMS regulations require MAOs to report and return identified overpayments. CMS believes that this requirement will reduce improper payments by encouraging MAOs to submit accurate payment information. In FY 2019, MAOs reported and returned approximately $44.55 million in self-reported overpayments.

Training: CMS conducted training sessions for Medicare Part C and Part D sponsors on program integrity initiatives, investigations, data analyses, and potential fraud schemes. In FY 2019, CMS conducted: two small in-person Medicare Parts C and D Fraud, Waste, and Abuse Collaboration Missions (October 2018 and March 2019); a large in-person Fraud, Waste, and Abuse Training (July 2019); and two Opioid Missions (April 2019 and August 2019). The missions included multi-disciplinary teams of experts and decision makers from CMS and its partners, and allowed them to undertake collaborative efforts to protect the Medicare Part C and D programs.

MIP6: Reduce the Percentage of Improper Payments Made under the Part D Prescription Drug Program

Measure	FY	Target	Result
MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program*	2021	TBD	November 15, 2021
	2020	0.74% (target in FY 2019 AFR)	November 15, 2020
	2019	1.65% (target in FY 2018 AFR)	0.75% (Target Exceeded)
	2018	1.66% (target in FY 2017 AFR)	1.66% (Target Met)
	2017	3.30% (target in FY 2015 AFR)	1.67% (Target Exceeded)
	2016	3.40% (target in FY 2013 AFR)	3.41%** (Target Met)
	2015	3.5% (target in FY 2013 AFR)	3.6% (Target Not Met)
	2014	3.6% (target in FY 2013 AFR)	3.3% (Target Exceeded)
	2013	3.1% (target in FY 2011 AFR)	3.7% (Target Not Met)

* Prior years' targets and results for this goal can be found in previous CMS Budgets and HHS AFRs.
** CMS uses Improper Payments Elimination and Reduction Act (IPERA) standards, rather than GPRAMA standards, for performance reporting on improper payments. According to A-123 guidance on IPERA, programs with established valid and rigorous estimation methodologies should count reduction targets as being met if the 95% confidence interval includes the reduction target.

In FY 2019, CMS exceeded its target of 1.65 percent, reporting an actual improper payment estimate of 0.75 percent, or $607.94 million. The decrease from the prior year's estimate of 1.66 percent resulted from errors being smaller in magnitude.

The FY 2020 target is 0.74 percent. The FY 2021 target will be established in the FY 2020 Agency Financial Report (AFR); per OMB, starting with FY 2017, CMS will establish a target for only the next fiscal year.

The Part D program payment error estimate reflects the extent to which Prescription Drug Event (PDE) records submitted by Part D sponsors for a national sample of PDEs, are substantiated by supporting documentation such as prescription record hardcopies, long-term care medication orders, and claims information from Part D sponsors. Validation of PDEs is performed during CMS's annual Payment Error Related to Prescription Drug Event Data Validation (PEPV) process, where supporting documentation is reviewed by two separate clinicians. To calculate the Part D program's error estimate, the dollars in error are divided by the overall Part D payments for the year being measured.

CMS has implemented three key initiatives, described below, to improve payment accuracy in the Part D program:

Outreach: CMS continued formal outreach to plan sponsors for invalid or incomplete documentation. CMS distributed Final Findings Reports to all Part D sponsors participating in the PDE review process. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.

Overpayment Recoveries Related to Regulatory Provisions: As required by the Social Security Act, CMS requires Part D sponsors report and return all identified overpayments. CMS believes that overpayment statute and regulation contributed to increased attention to data accuracy by Part D sponsors. In FY 2019, Part D sponsors self-reported and returned approximately $1.54 million in overpayments.

Training: CMS continued national training sessions on payment and data submission with detailed instructions as part of the improper payment estimation process for Part D sponsors. CMS also conducted in-person training sessions for Medicare Part C and Part D sponsors on program integrity initiatives, investigations, data analysis, and potential fraud schemes. In FY 2019: CMS conducted two small in-person Medicare Parts C and D Fraud, Waste, and Abuse Collaboration Missions (October 2018 and March 2019); a large in-person Fraud, Waste, and Abuse Training (July 2019); and two Opioid Missions (April 2019 and August 2019). The missions included multi-disciplinary teams of experts and decision makers from CMS and its partners, and supported collaborative efforts to protect the Medicare Part C and D programs.

MIP9: Reduce the Improper Payment Rates in the Medicaid Program and the Children's Health Insurance Program (CHIP)

Measure	FY	Target	Result
MIP9.1: Reduce the Improper Payment Rate in the Medicaid Program*	2021	N/A[1]	N/A[1]
	2020	N/A[1]	N/A[1]
	2019	N/A[1]	14.90%[1]
	2018	7.93%	9.79% (Target Not Met)
	2017	9.57%	10.10% (Target Not Met)
	2016	11.53%	10.48% (Target Exceeded)
	2015	6.7%	9.78% (Target Not Met)
	2014	5.6%	6.70% (Target Not Met)
	2013	6.4%	5.8% (Target Exceeded)
MIP9.2: Reduce the Improper Payment Rate in the Children's Health Insurance Program (CHIP)*	2021	N/A[1]	N/A[1]
	2020	N/A[1]	N/A[1]
	2019	N/A[1]	15.83[1]
	2018	8.20%	8.57% (Target Not Met)
	2017	7.38%	8.64% (Target Not Met)
	2016	6.81%	7.99% (Target Not Met)
	2015	6.5%	6.80% (Target Not Met)
	2014	Report rolling improper payment rate in the 2014 AFR.	6.50% (Target Met)
	2013	Report rolling improper payment rate in the 2013 AFR.	7.1% (Target Met)

* Prior years' targets and results for this goal can be found in previous CMS Budgets and HHS AFRs.

[1] 2019 is the first year reporting the eligibility component is resumed, therefore targets will not be established until all three cycles have been measured for eligibility. The FY 2021 AFR will report a target established for 2022.

The Payment Error Rate Measurement (PERM) program measures improper payments for the Fee-For-Service (FFS), Managed Care, and eligibility components in both Medicaid (MIP9.1) and the Children's Health Insurance Program (CHIP) (MIP9.2). CMS measures improper payments in 17 states each year to calculate a rolling, three-year national improper payment rate for both Medicaid and CHIP. The national Medicaid and CHIP improper payment rates reported in the FY 2019 HHS AFR were based on measurements that were conducted in FYs 2017, 2018, and 2019. Information on the Medicaid and CHIP statistical sampling process and review period can be found in the 2019 HHS AFR.

The national Medicaid improper payment estimate for FY 2019 is 14.90 percent or $57.36 billion. The national Medicaid component rates are 16.30 percent for Medicaid FFS, 0.12 percent for Medicaid managed care and 8.36 percent for the Medicaid eligibility component.

Since FY 2014, the Medicaid improper payment estimate has been driven by errors due to state noncompliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. Most improper payments cited on claims are those where a newly enrolled provider had not been appropriately screened by the state, a provider did not have the required NPI on the claim, or a provider was not enrolled. Although these errors remain a driver of the Medicaid rate, state compliance has improved as the Medicaid FFS improper payment rate for these errors decreased from 7.21 percent in FY 2018 to 6.28 percent in FY 2019.

While the screening errors described above are for newly enrolled providers, states also must revalidate the enrollment and rescreen all providers at least every 5 years. States were required to complete the revalidation process of all existing providers by September 25, 2016. In FY 2019, HHS measured the second cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major error source in the Medicaid improper payment rate. HHS will complete the measurement of all states for compliance with provider revalidation requirements in FY 2020.

Another area driving the FY 2019 Medicaid improper payment estimate is the reintegration of the PERM eligibility component. This is the first time in the history of the program that the eligibility component measurement has been conducted by a federal contractor; previously states conducted the measurement and self-reported results to HHS for reporting the national rate. This allows for consistent insight into the accuracy of Medicaid eligibility determinations and increases the oversight of identified vulnerabilities. Based on the measurement of the first cycle of states, eligibility errors are mostly due to insufficient documentation to verify eligibility or noncompliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification was not done at all and where there is indication that the verification was initiated but there was no documentation to validate the verification process was completed. These insufficient documentation situations are related primarily to income or resource verification. HHS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

The national CHIP gross improper payment estimate for FY 2019 is 15.83 percent or $2.74 billion. The national CHIP component rates are 13.25 percent for CHIP FFS, 1.25 percent for CHIP managed care and 11.78 percent for the CHIP eligibility component.

One area driving the FY 2019 CHIP improper payment estimate is the FY 2019 reintegration of the PERM eligibility component. This is the first time in the history of the program that the eligibility component measurement has been conducted by a federal contractor; previously states conducted the measurement and self-reported results to HHS for reporting the national rate. This allows for consistent insight into the accuracy of CHIP eligibility determinations and increases the oversight of identified vulnerabilities. Based on the measurement of the first cycle of states, eligibility errors are mostly due to insufficient documentation to verify eligibility or noncompliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification was not done at all and where there is indication that the verification was initiated but there was no documentation to validate the verification process was completed. These insufficient documentation situations are related primarily to income verification. The CHIP improper payment rate was also driven by claims where the beneficiary was ineligible for CHIP, but was eligible for Medicaid, again, mostly related to beneficiary income. HHS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

Additionally, since FY 2014, improper payments cited on claims where a newly enrolled provider or a provider due for revalidation had not been appropriately enrolled and screened by the state or a provider did not have the required NPI on the claim have also driven the CHIP rate. Although these errors remain a driver of the CHIP rate, state compliance with the newly enrolled provider requirements has improved as the CHIP FFS improper payment rate for these errors decreased from 7.73 percent in FY 2018 to 6.02 percent in FY 2019.

The factors contributing to improper payments are complex and vary from year to year. In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and submit states-specific Corrective Action Plans (CAPs) to CMS. Each year, CMS also outlines actions the agency will implement to prevent and reduce improper payments for all error categories on a national level. Detailed information on corrective actions can be found in the 2019 HHS AFR.

MIP11: Improve Efficiency in the Medicare Enrollment Process by Increasing the Proportion of Providers Initially Enrolling in the Medicare Program Online

Measure	CY	Target*	Result
MIP11: Increase the proportion of providers performing initial enrollment in the Medicare Program online.	2021	50%	April 30,2022
	2020	46%	April 30, 2021
	2019	44%	April 30, 2020
	2018	38.7%	49.11% (Target Exceeded)
	2017	36.7%	42.51% (Target Exceeded)
	2016	34%	34.7% (Target Exceeded)
	2015	Baseline	30.1%

* This is a CY goal. The baseline was established in CY 2015 when the result was measured at 30.1 percent. The CY 2016 target was established at 34 percent, based on the expectation of a modest increase over the baseline result. Consistent with this concept, the subsequent years have been based on a 2-4 percent per year increase. Now that the actual result exceeds the future target, CMS increases the 2021 goal to 4 percent.

The Medicare Provider Enrollment, Chain, and Ownership. System (PECOS) is the CMS national repository and system of record for all enrollment information on Medicare providers and suppliers. Providers and suppliers are required to enroll in the Medicare program in order to bill and receive payment for items and services provided to program beneficiaries. As an online electronic application system, PECOS helps to improve operational efficiency in CMS' enrollment process, reduce the cost associated with processing paper enrollment applications, and improve beneficiary access to care by reducing the time needed to issue provider certifications. This measure identifies annual improvement (increases) in electronic applications for initial enrollments that provide savings.

The purpose of the measure is to increase online submission of enrollment applications and reduce the number of paper applications, thereby increasing operational efficiency. Further information or explanation for paper applications necessitates the return of an estimated 50 to 70 percent of applications. This process unnecessarily lengthens the provider enrollment timeframe and increases the CMS enrollment contractors' time and effort when processing enrollment applications. This added time and expense negatively impacts CMS' operational efficiency and can affect program beneficiaries' access to services. The average time to process an electronic enrollment application is 45 days. This compares favorably to the 60 days average time for processing a paper enrollment. The annual average of more than a million enrollment applications processed by CMS further amplifies this difference.

This measure improves operational efficiency by reducing the number of hours needed to process enrollment applications by Medicare Contractors through PECOS, resulting in

reduction of operating costs and improvement of access to care through timelier provider certification. Increasing usability of online enrollment submissions by providers will also result in more complete applications and faster screening results through real time data verification to the Medicare contractors, reducing overall processing time. The online enrollment application supplies information needed by the provider with quick and easy access to update the information. The electronic enrollment process also enhances CMS' capacity to perform its responsibilities under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP). The QPP relies on PECOS data for Merit-Based Incentive Payment System (MIPS) eligibility. States leverage PECOS data for screening and enrollment of Medicaid fee-for-service providers. Faster processing and timely updates of enrollment information in PECOS facilitates data sharing and the identification and determination of the eligibility of providers and groups in MACRA programs such as MIPS, Alternative Payment Models, and State Medicaid Agencies.

CMS is measuring the increase in the proportion of providers enrolling online. The baseline measurement was established in CY 2015 and goal implementation occurred in the calendar year (CY) 2016.

The CY 2016 result was 34.7 percent, which exceeded the target of 34 percent. The CY 2017 result was 42.51 percent, which exceeds the target of 36.7 percent. The CY 2018 result was 49.11 percent, which exceeds the target of 38.7 percent. Targets set for CY 2019 (44 percent), CY 2020 (46 percent) and CY 2021 (50 percent) with subsequent measurements available by April of the year following the calendar year measured.

MIP12: Savings from the Prevention of Improper Medicare Payments by Successful Implementation of Fraud Prevention System (FPS) Edits

Measure	FY	Target*	Result
MIP12: Maintain or increase dollar savings through the prevention of improper payments in Medicare Fee For Service (FFS) claims through innovative edit techniques employed by Fraud Prevention System (FPS) Edits	2021	$33.5 million	April 30, 2022
	2020	$33.5 million	April 30, 2021
	2019	$33.5 million	April 30, 2020
	2018	$33.0 million	$57.8 million (Target exceeded)
	2017	Baseline	$32.1 million

* The FY 2017 baseline for this goal is $32.1 million. The targets for FY 2018 through FY 2021 are based on previous years' results, coupled with expected changes in the program. These targets are expressed as dollar savings achieved through prevention, and represent a percentage change from the previous year. CMS calculates the savings metric three months after the end of the fiscal year. This three-month run out time is due to the fact that CMS' methodology captures denials/rejections that were resubmitted or overturned on appeal within the three months after the end of the fiscal year. The FPS edits methodology was certified by the Office of Inspector General in the FPS 3rd Implementation Year Report to Congress.

To protect the integrity of the Medicare Trust Funds, CMS must ensure Medicare payments are correct and made to legitimate providers for covered, appropriate, and reasonable services for eligible beneficiaries. This goal targets CMS's ability to prevent improper payments by measuring the dollar savings resulting from claims rejected or denied based on FPS edits. For the purpose of this measure, savings measured by this goal include rejected claims that are not resubmitted, and denied claims not overturned on appeal within three months after the end of the reporting period.

FPS edits screen Medicare FFS claims on a pre-payment basis for improper billing, which could result from miscoding, or could indicate intentional fraud, waste, or abuse. The FPS has the capability to prevent payment of certain improper claims by communicating a denial or rejection message to the claims payment systems. CMS tested FPS's ability to successfully integrate with several legacy claims processing systems in early 2014. This test validated the capabilities of the FPS system to prevent improper payments in an automated fashion, without the need for human intervention.

CMS has also identified ways that FPS edits could address vulnerabilities in other systematic edits. CMS found that the FPS is more capable of sophisticated data analysis on claims than other systems where edits occur (e.g., the Fiscal Intermediary Standard System (FISS)). The FPS is coded in a way that looks for these types of patterns and still catches the outliers. The FPS also is the only editing system that is built in a manner to allow for the coding of "families" of edits, which are edits that are designed based on similar Medicare policy. Edits that come from edit families are easier to implement, which is an advantage that FPS has over other systems.

CMS continues to develop new edits for implementation on Part A, Part B, and Durable Medical Equipment (DME) claims. An example of a DME edit is one where the patient needs to have a corresponding Part A claim to receive payment for a DME claim. The edit checks a patient's claims history in one system (e.g., the FISS, which processes Medicare Part A and some Medicare Part B claims) to determine eligibility in the ViPs Medicare System (VMS), which processes DME payments. The FPS system is able to accomplish this data analysis, across time and across Medicare Administrative Contractor (MAC)

jurisdictions. CMS is also working on FPS edits that measure accumulated services over a rolling time period (for example, five services allowed in a rolling one-year timeframe), such as facet joint injections, or a service that is allowed once every month. These edits will deny payment for services exceeding those limits.

Through collaboration with many stakeholders, CMS has developed a process to identify opportunities for the FPS to standardize editing across all MACs for certain billing scenarios. For example, if multiple MACs have similar Local Coverage Determinations, the FPS can implement a single edit on a nationwide basis, in lieu of having each MAC implement a local edit. The first such edit was launched in 2015.

The increase in savings from FY 2017 to FY 2018 was mainly driven by two FPS edits: the New vs. Established Patient Part B edit and the Peripheral Nerve Stimulation edit. The New vs. Established Patient Part B edit rejects new patient visits billed for patients who have already been established with the Part B rendering provider within a three-year period. Savings for this edit increases mainly because the edit was implemented in February 2017 and thus only active for part of the fiscal year. The Peripheral Nerve Stimulation edit was originally designed to deny Part B claims when more than two dates of service were billed within 365 days for the same beneficiary with procedure code 64555. In FY 2018, the edit was enhanced to also deny procedure code L8679 when more than two dates of service were billed within 365 days for the same beneficiary. The addition of this procedure code in FY 2018 was a key reason why savings increased for this edit.

Due to a desire to reflect Small Business Jobs Act (SBJA) statutorily mandated changes in CMS fraud prevention work, as well as difficulties and anomalies in the reporting systems and data collection used to measure goal performance, the design of this goal considers the changes made to FPS (1.0) during its existence, and implements in FPS 2.0. The changes promote alignment with CMS initiatives in targeting high risk providers, through a risk-based supplier and provider screening process and the SBJA, which added new requirements to use advanced predictive analytics to identify high risk providers for Medicare FFS claims. With funding authorized in the SBJA, CMS developed the FPS. It is the provisions in these Acts, and the improved tracking system using FPS, that forms the basis for this goal. It is also important to note that while the FPS enhances CMS' capacity to target improper payments, CMS continues to implement policy changes and other initiatives that may have an impact on Medicare improper payments year to year. The methodology of this measure strives to capture only the effects of the FPS edits; larger changes to payment systems may impact the annual measure as well, and shall be considered when assessing the outcomes of this measure.

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MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

QIO7: Make Nursing Home Care Safer via the National Nursing Home Quality Care Collaboration (NNHQCC)

Measure	FY	Target	Result
QIO 7.2: Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes	2020	Discontinued	N/A
	2019	5%	Data not available
	2018	6%	4.4% (Target Exceeded)
	2017	Historical Actual	4.6%
	2016	Baseline	8%
Measure	**FY**	**Target**	**Result**
QIO7.3: Demonstrate improvement in nursing home health care quality by reducing the number of one-star nursing homes DEVELOPMENTAL	2021	TBD*	TBD
	2020	Develop New Baseline (based on 2019 data)	April 30, 2020

* The future targets will be determined when a new baseline is set.

More than 3 million Americans rely on services provided by nursing homes each year. There are 1.4 million Americans who reside in the nation's more than 15,000 nursing homes on any given day. Current law requires CMS to develop a strategy that will guide local, state, and national efforts to improve the quality of care in nursing homes. CMS' approach to oversight of nursing homes is constantly evolving and is a priority of the Administrator.

In December 2008, CMS added a star rating system to the Nursing Home Compare website which serves three purposes: 1) to provide residents and their families with an assessment of nursing home quality, 2) to make a distinction between high and low performing nursing homes, and 3) to provide incentives for nursing homes to improve their performance. A one-star rating is the lowest rating and a five-star rating is the highest.

The Quality Innovation Network-Quality Improvement Organization (QIN-QIO), via recruitment of nursing homes and other activities, supported the creation of a National Nursing Home Quality Care Collaborative (NNHQCC) whose purpose is to ensure, along with its partners, that every nursing home resident receives the highest quality of care. Specifically, the QIN-QIO supports the Collaborative's objective to "instill quality and

performance improvement practices, eliminate healthcare acquired conditions, and improve resident satisfaction." The QIN-QIO recruited nursing homes with an existing star status and all nursing homes or facilities providing long-term care services to Medicare beneficiaries are eligible and encouraged to participate in the Collaborative.

Nursing homes participating in the NNHQCC focus on processes that improve their systems and measure individual tests of change including: review of their PDSA improvement cycle results, clinical outcomes measures and measures of quality improvement. Nursing homes participating in the NNHQCC are encouraged to improve quality as a whole rather than focus on any one measure, therefore, the fifteen measures of the total quality score appropriately reflect general quality improvement. A reduction in the percentage of homes that receive the lowest quality score would indicate progress in the hardest to reach nursing homes.

One-star nursing homes face specific challenges including: lack of understanding of quality improvement processes, lack of resources to implement the processes, poor understanding of the data for use in improvement, lack of consistent leadership, and perhaps lower resident and family engagement.

The measure "quality improvement in one star nursing homes" tracks the change in the percentage of nursing homes with a one-star quality rating, over time. CMS monitors quality improvement progress generated at the national, QIN-QIO, and nursing home levels using the quality domain of CMS' Five Star Rating System because of its capacity to influence this specific domain most effectively.

In April 2019, improvements were made to each of the rating system domains under the Five Star Quality Rating System as part of an ongoing effort to improve information available to the public and drive quality improvement amongst nursing homes. Included as part of the improvements are new Quality Measure (QM) rating thresholds, implementation of a process for continual improvement of QM thresholds (thereby increasing thresholds every 6 months) new QM weights and scoring and changes to certain measures as described in the Quality, Safety and Oversight Group Memo QSO-19-08-NH and the Nursing Home Compare Five-Star Quality Rating System: Technical User's Guide. Due to the change in the methodology of how data is collected for the quality component of the Five Star Quality Rating System, the current reporting methodology is no longer valid and a new measure, baseline and future targets are expected to be developed for this goal Spring 2020.

Partial results are reported for 2018, indicating that the target of 6% was exceeded by reducing the percentage of one-star nursing homes to 4.4%. CMS does not have actual comparable data for 2019, however we can project that the 2019 target of 5% would likely have been exceeded.

QIO8: Strengthening Person and Family Engagement in Beneficiary Health Care Quality by Increasing Satisfaction of Quality of Care Compliant Resolution

Measure	FY	Target	Result
QIO8: Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints.	2021	80% QIO Satisfaction	January 15, 2022
	2020	80% QIO Satisfaction	January 15, 2021
	2019	75% QIO Satisfaction	81.1% (Target Exceeded)
	2018	75% QIO Satisfaction	83.3% (Target Exceeded)
	2017	70% QIO satisfaction	67.8% (Target Not Met)
	2016	62% - Baseline	65.7% (Target Met)

The primary focus of the Beneficiary and Family Centered Care (BFCC) is to improve healthcare services for Medicare beneficiaries, through the Quality Improvement Organization (QIO) performance of statutory review functions. This includes, but is not limited to: quality of care reviews, beneficiary complaint reviews, discharge and termination of service appeals in various provider settings, medical necessity reviews, and the Emergency Medical Treatment and Labor Act (EMTALA) reviews. Beneficiary satisfaction with the QIO review process has been mixed over the course of the past several years, with concerns raised by patients and families regarding the quality of the reviews and the impartiality of the reviewers.

The BFCC QIOs develop activities that engage patients and families, with the goal of increasing patient knowledge, skill, and confidence in taking an active role in managing patient health care. Engagement in these activities is captured on the Beneficiary Satisfaction surveys. The current survey measures satisfaction for Quality of Care Reviews and Appeals Reviews. The BFCC Oversight and Review Center (ORC) began administering the satisfaction survey in April 2016, beginning with cases closed in November 2015 and continuing to the present. CMS began receiving QIO performance data for satisfaction, beginning in July 2016. The 11th Scope of Work (SOW) survey scoring was used to develop the targets for this goal prior to FY 2020 and the 12th SOW is being used for target development as of FY 2020.

On June 8, 2019 the 12th SOW was implemented and as a result, Medicare beneficiaries in each state, may have a different BFCC-QIO serving their state. During this transition to the 12th SOW, BFCC-QIO statutory review functions continued without disruption.

The survey is mailed monthly to randomly-chosen Medicare beneficiaries, who file a Quality of Care Complaint or Appeal, and agree to participate in the survey. Beneficiaries share their views about their experience with the BFCC-QIO and the Medicare Complaint or

Appeal process. The survey assesses beneficiary satisfaction in three domains which include:

(1) Effectiveness of the QIO review process;
(2) Courtesy & Respect of BFCC-QIO staff in handling a beneficiary's complaint; and
(3) Responsiveness of BFCC QIO staff.

BFCC QIOs continue to sustain good-levels of performance. The FY 2019 target was exceeded.

QIO11: Improve Hospital Patient Safety by Reducing Preventable Patient Harms

Measure	CY	Target	Result
QIO11: Hospital Patient Safety Harm Reduction Baseline: CY 2014: 98 harms per 1,000 discharges based on revised baseline	2021	**TBD	January 31, 2023
	2020	**TBD	January 31, 2022
	2019	78 harms per 1,000 discharges	January 31, 2021
	2018	82 harms per 1,000 discharges	April 30, 2020
	2017	86 harms per 1,000 discharges	86*(Target Met)
	2016	Historical Actual	88
	2015	Historical Actual	92

*Data are preliminary based on partial data from this calendar year. The estimates are subject to change after all data from this calendar year are available and all quality control procedures have been completed.
**Targets will reflect a 2% annual reduction when the new baseline is established for 2019-2024.

The purpose of this measure is to track national progress on harm reduction in acute care hospitals and assess the impact of patient safety efforts by using a national chart abstracted sample and counting the number of patient harms that take place per 1,000 discharges. Examples of some of the preventable patient harms included in this measure are:

- Adverse Drug Events (ADEs)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infections (CLABSI)
- Falls
- Pressure Ulcers (PrU), also known as Pressure Injuries
- Surgical Site Infections (SSI)
- Ventilator-Associated Pneumonia/Events (VAP/VAE)
- Venous Thromboembolism (VTE) and
- Hospital Readmissions

These harms can result in additional pain, stress, and even death while increasing treatment costs to both the patient and the Medicare Trust Fund. The Hospital Acquired Condition rate utilizes the Agency for Healthcare Research and Quality's (AHRQ) National Scorecard, which is derived from hospital charts abstracted from a nationally representative sample of charts annually. The sampling methodology includes abstracting clinically relevant, highly standardized national hospital safety metrics. This system is in active operation and was originally put into place to measure national patient safety efforts led by

CMS' Hospital Improvement Innovation Network (HIIN). By itself, however, it represents an enormous contribution to the government's ability to measure, monitor, and improve patient safety at a national scale. As a composite of many different harms, the AHRQ National Score Card also includes data from the Centers for Disease Control (CDC's) National Healthcare Safety Network (NHSN) and AHRQ's Healthcare Cost and Utilization Project (HCUP) databases. Historically, this dataset has allowed the government to demonstrate a reduction in harm from 145 harms per 1,000 discharges in the original baseline year of 2010, to 92 harms per 1,000 discharges in CY 2015. These data demonstrate a reduction in harm to patients of approximately 21 percent over five years National Scorecard on Rates of Hospital-Acquired Conditions 2010 to 2015.

These declines in hospital-acquired conditions parallel the earlier gains achieved between 2010 and 2014, where hospital-acquired conditions overall dropped 17 percent, saving $19.9 billion in health care costs and preventing 87,000 deaths. Between the revised 2014 baseline and 2016, CMS achieved an 11% decline, resulting in an estimated 530,000 fewer hospital acquired conditions - 13,100 lives saved from harms avoided and $4.7 billion in costs saved. To review the full HAC report please see: AHRQ National Scorecard on Hospital-Acquired Conditions.

Beginning in 2016, the all cause harm metric was calculated differently due to two significant events that impacted the calculation (i.e., Hospital Inpatient Quality Reporting (IQR) Program changes and the ICD-9 to ICD-10 conversion). CMS anticipates other changes to the sampling methodology. The target will need to be made after 2019 based on improved definitions and another realignment for 2020 and beyond is required for the sampling methodology. Beginning in 2019, CMS expects to reduce patient harm by 10 percent by 2024 and set new annual targets based on 2 percent decrease per year.

MEDICARE BENEFITS

MCR1: Ensure Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive

Measure	FY	Target	Result
MCR1.1a: Maintain or exceed percent of beneficiaries in Medicare Fee-for-Service (FFS) who report access to care* Baseline: 91% (FY 2007)	2021	Contextual Indicator	December 31, 2021
	2020	Contextual Indicator	December 31, 2020
	2019	Contextual Indicator	92%
	2018	Contextual Indicator	91%
	2017	Contextual Indicator	91%
	2016	Contextual Indicator	90%
	2015	90%	91% (Target Exceeded)
	2014	90%	91% (Target Exceeded)
	2013	90%	91% (Target Exceeded)
MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care * Baseline: 90% (FY 2007)	2021	Contextual Indicator	December 31, 2021
	2020	Contextual Indicator	December 31, 2020
	2019	Contextual Indicator	90%
	2018	Contextual Indicator	91%
	2017	Contextual Indicator	91%
	2016	Contextual Indicator	90%
	2015	90%	90% (Target Met)
	2014	90%	90% (Target Met)
	2013	90%	91% (Target Exceeded)

* Prior years' targets and results for this goal can be found in previous CMS Budgets.

CMS has monitored Medicare FFS and MA access to care as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. CMS is continuing to monitor FFS and MA access to care in order to maintain the same high rates for its beneficiaries. To measure these rates, beneficiaries respond to the following question in the Medicare Consumer Assessment of Healthcare Providers and Systems survey: "Percent of persons with FFS (or MA Plans) that report they usually or always get needed care right away, as soon as they thought they needed it." CMS has met or exceeded its targets for this goal since the inception of the goal. Since FY 2016, CMS has reported the data trend annually as a contextual measure. High rates have continued for this measure.

MCR23: Reduce the Average Out-of-Pocket Share of Prescription Drug Costs while in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non-Low Income Subsidy (LIS) Medicare Beneficiaries who Reach the Gap and have no Supplemental Coverage in the Gap

Measure	FY	Target	Result
MCR23: Reduce the Average Out-of-Pocket Share of Prescription Drug Costs while in the Medicare Part D Prescription Drug Benefit Coverage Gap for Non-Low Income Subsidy (LIS) Medicare Beneficiaries who Reach the Gap and have no Supplemental Coverage in the Gap	2021	25%	April 30, 2023
	2020	25%	April 30, 2022
	2019	28%	April 30 2021
	2018	37%	April 30, 2020
	2017	43%	42% (Target Exceeded)
	2016	48%	48% (Target Met)
	2015	50%	49% (Target Exceeded)
	2014	53%	53% (Target Met)
	2013	55%	52% (Target Exceeded)
	2012	58%	57% (Target Exceeded)
	2011	60%	57% (Historical Actual)
	2010	N/A	Baseline = 100%

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), amends Title XVIII (Medicare) of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception, Medicare Part D has significantly increases the number of beneficiaries with comprehensive drug coverage, and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit, did Medicare coverage recommence. This is known as the coverage gap (or “donut hole”). For 2020, this “gap” in coverage is above $4,020 in total drug costs, and up until a beneficiary spends $6,350 out-of-pocket.

Since 2011, brand-name (applicable) pharmaceutical manufacturers have been required to provide a 50 percent discount on the negotiated price of their drugs while a beneficiary is in the coverage gap. Public Law No. 115-123, also known as the Bipartisan Budget Act of 2018 (BBA), enacted on February 9, 2018, increased the manufacturer discount for beneficiaries in the gap from 50 to 70 percent and reduced beneficiary cost sharing to 25 percent in 2019 for applicable drugs. The BBA’s change to the Coverage Gap Discount Program was such that the gap for brand drugs closed a year earlier than had been established in the MMA. The discount applies at the point of sale, and both the beneficiary

cost sharing and the manufacturer discounts count toward the annual out-of-pocket threshold (known as True Out-of-Pocket Costs or TrOOP). Since 2013, Part D Plans are requiredd to cover a portion of the costs of applicable drugs in the coverage gap as well, with this coverage increasing over time from 2.5 percent in 2013 to 25 percent by 2020. However, because of changes made in the BBA that shift more liability to manufacturers, plans will now be responsible for just 5 percent of applicable drug costs in the gap for 2019 and beyond. Since 2011, Part D Plans are also requiredd to cover a portion of the costs for generic drugs in the coverage gap, starting with 7 percent in 2011 and increasing to 75 percent for 2020 and beyond. Notably, the BBA did not change the existing schedule for beneficiary cost sharing for non-applicable drugs (generics). This performance measure reflects CMS' effort to reduce the average out-of-pocket costs paid by non-Low Income Subsidy (LIS) Medicare beneficiaries while in the coverage gap. For 2020 and beyond, the beneficiary, on average, will only be responsible for 25 percent of the costs of both generic and brand name drugs while in the coverage gap, making this coverage equivalent to coverage prior to reaching the gap.

CMS' tracking of this measure has shown that that in most years non-LIS out-of-pocket costs have decreased beyond the targets required by statute (57 percent compared to 58 percent in 2012, 52 percent compared to 55 percent in 2013, and 49 percent compared to 50 percent in 2015). The statute which established the Coverage Gap Discount Program gave CMS the authority to authorize exceptions to the requirement that manufacturers have their applicable drugs be covered under a Coverage Gap Discount Program agreement (Section 1860D-43 (C)) in extenuating circumstances. However, CMS successfully encourages all manufacturers of applicable drug products to participate in the program, which results in the consistent application of discounts for all branded products. Furthermore, the infrastructure which has been put in place treats manufacturers fairly, which has resulted in manufacturers choosing to stay in the Part D program. Specifically it: 1) allows public access to information about which manufacturers are participating in the program, and 2) offers an equitable process for manufacturers to dispute invoiced amounts. This has occurred without any meaningful decreases in manufacturer participation in the Part D market. As generic utilization in the Part D program has remained static, and very high (over 75 percent since 2012), that is not a strong contributor to the success of this goal. Rather, CMS' application and management of the Coverage Gap Discount Program, coupled with the strong incentives for manufacturers to participate in the Part D program, are the primary drivers of this goal's success.

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CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP3: Improve Availability and Accessibility of Health Insurance Coverage by Increasing Enrollment of Eligible Children in CHIP and Medicaid

Measure	FY	Target	Result
CHIP3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid* 2008 Baseline: 37,311,641 children	2021	46,672,893 children (Medicaid – 37,338,314/CHIP – 9,334,579)	March 31, 2022
	2020	46,672,893 children (Medicaid – 37,338,314/CHIP – 9,334,579)	March 31, 2021
	2019	46,556,502 children (Medicaid - 37,245,202/CHIP - 9,311,300)	March 31, 2020
	2018	46,440,401 children (Medicaid – 37,152,321/CHIP – 9,288,080)	45,919,430 children (Medicaid - 36,287,063/CHIP - 9,632,367) (Target Not Met)
	2017	46,062,581 children (Medicaid – 36,850,065/CHIP – 9,212,516	46,322,217 children (Medicaid – 36,862,057/CHIP – 9,460,160) (Target Exceeded)
	2016	45,271,662 children (Medicaid – 36,217,330/CHIP – 9,054,332)	45,980,595 children (Medicaid - 37,080,521/ CHIP - 8,900,074) (Target Met)
	2015	47,642,385 children (Medicaid – 38,920,959/CHIP – 8,721,426)	45,201,455 children (Medicaid – 36,834,253/CHIP – 8,367,202) (Target Not Met)
	2014	46,617,385 children (Medicaid – 38,083,596/CHIP – 8,533,789)	43,689,824** children (Target Not Met)
	2013	45,592,385 children (Medicaid – 37,246,233/CHIP – 8,346,152)	45,292,410 children (Medicaid – 37,198,483/CHIP – 8,093,927) (Target Not Met)

* Prior years' targets and results for this goal can be found in previous CMS Budgets.

** CMS is unable to provide the Medicaid/CHIP enrollment totals for 2014 due to state data limitations.

The purpose of this measure is to increase enrollment in CHIP and Medicaid from 43,542,385 children in FY 2011 to 46,672,893 children by the end of FY 2021. Under the CHIP and Medicaid programs, States submit quarterly and annual statistical forms, which report the number of children who are enrolled in Medicaid, separate CHIP programs, and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year.

This measure should be considered in the context of a recent Urban Institute Analysis highlighting 2017 data that show that nationally, 93.1 percent of children eligible for Medicaid and CHIP are enrolled in these programs, with participation rates at or above 90 percent in 45 states. There is a declining enrollment trend in total Medicaid and CHIP enrollment over the past year. There are a number of factors that impact enrollment in Medicaid and CHIP, including: the economy, state eligibility system functionality, and state operations (e.g., ability to receive and process applications and conduct timely redeterminations annually or when there is a change in circumstances). Some of these considerations, such as a strong economy, state systems and operational issues, and reducing backlog of delayed redeterminations may account for the FY 2018 decline in Medicaid and CHIP enrollment, among others. Each of the factors may impact states and their enrollment trends differently. For example, states experiencing losses in Medicaid and CHIP enrollment may also be experiencing a decrease in unemployment rates, indicating an improving economy. The improving economy may account for the enrollment decline in some of these states, while in others, enrollment declines may actually be the result of state system and operational issues.

In contrast, in 2008, only five States had participation rates of at least 90 percent. With such gains in increasing children's participation in Medicaid and CHIP, it is important to note that the remaining eligible uninsured children will be the hardest to reach. CMS' strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with its State and Federal partners, continuing to implement statutory provisions that encourage program simplification, supporting CHIP outreach grantees, and bolstering its data collection activities.

Many factors affect enrollment figures in CHIP and Medicaid, including states' economic situations, programmatic changes, efficiency of state eligibility and enrollment processes, and the accuracy and timeliness of state reporting.

The HEALTHY KIDS Act, as included in P.L. 115-120, extended CHIP funding for six years through FY 2023, and the ACCESS Act, as included in P.L. 115-123, provides CHIP funding for an additional four years, for FY 2024 through FY 2027. The HEALTHY KIDS Act and the ACCESS Act also included provisions related to the extension and reduction of federal financial participation for CHIP and maintenance of effort for children's Medicaid and CHIP coverage, and the extension of express lane eligibility and the Connecting Kids to Coverage Outreach and Enrollment Program.[8] Through the HEALTHY KIDS Act and the

[8] Key provisions of the HEALTHY KIDS Act and the ACCESS Act are described in State Health Official Letter# 18-010.

[3]Enrollment grants have been awarded to a variety of community organizations—such as health care providers, schools, tribal organizations, and other types of nonprofits—through four, two-year funding cycles since 2009. Thus far, over 230 entities have received Connecting Kids to Coverage grants. The National Campaign conducts training webinars and works with partners on outreach, creates and updates existing outreach print materials, produces new social media graphics, and publishes a newsletter that has over 30,000 subscribers.

ACCESS Act, the Connecting Kids to Coverage Outreach and Enrollment grants and National Campaign, received $120 million in funding for outreach and enrollment activities through FY 2023, and $48 million for FY 2024 to FY 2027.

The Connecting Kids to Coverage grants and National Campaign fund activities that are aimed at reducing the number of children who are eligible for Medicaid and CHIP but are not enrolled, and improving retention of eligible children who are currently enrolled.[3] On November 30, 2018, CMS issued the Connecting Kids to Coverage HEALTHY KIDS 2019 Outreach and Enrollment Cooperative Agreement Notice of Funding Opportunity, which made available $48 million in cooperative agreements to states, local governments, Indian tribes, tribal consortium, urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act, federal health safety net organizations, community-based organizations, faith-based organizations, and schools. On June 19, 2019, CMS awarded 39 new cooperative agreements, with awarded amounts ranging from just over $360,000 to $1,500,000. These grants will have a 3-year period of performance beginning July 1, 2019. On July 17, 2019, CMS issued the Connecting Kids to Coverage HEALTHY KIDS American Indian/ Alaska Native (AI/AN) 2020 Outreach and Enrollment Cooperative Agreement Notice of Funding Opportunity, which made available $6 million in cooperative agreements to enroll and retain AI/AN children in Medicaid and CHIP. Eligible entities for this funding opportunity include Indian Health Service providers, Tribes and Tribal organizations operating a health program under a contract or compact with the Indian Health Service under the Indian Self Determination and Education Assistance Act, and Urban Indian organizations operating a health program under the Indian Health Care Improvement Act. We plan to announce the awards in January 2020.

Prior to these recent extenders, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), extended CHIP funding for two years, through September 30, 2017. MACRA also provided $40 million for the Connecting Kids to Coverage Outreach and Enrollment grants and National Campaign. The ACA extended federal CHIP funding for two years through September 30, 2015.

With 93.1 percent of eligible children enrolled in Medicaid and CHIP in 2017, effective and targeted strategies are needed to enroll the remaining 6.9 percent of eligible uninsured children. As noted above, the remaining eligible but uninsured children are the hardest to reach.

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CENTER OF MEDICARE AND MEDICAID INNOVATION (CMMI)

CMMI2: Identify, Test, and Improve Payment and Service Delivery Models

Measure	FY	Target	Result
CMMI2.1: Increase the number of model tests that currently indicate: 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost. Baseline: 1.0 FY 2014	2021	8.0	November 30, 2021
	2020	8.0	November 30, 2020
	2019	7.0	7 (Target Met)
	2018	6.0	6 (Target Met)
	2017	5.0	5 (Target Met)
	2016	4.0	4 (Target Met)
	2015	3.0	3 (Target Met)

CMS routinely and rigorously assesses the impact of each model on quality and cost. To formally evaluate models, evaluators employ advanced statistical methods and carefully define and select comparison groups, as appropriate, to ensure that models deemed to be successful, represent high-value investments of taxpayer dollars. Similarly, model teams often employ implementation contractors to apply rigorous self-monitoring methodologies that assess the performance of models and generate value-based payments.

The purpose of measure CMMI2.1 is to identify those models, based on available data that indicate cost savings and/or quality improvements. This measure reflects the documented progress that CMS is making toward sustainable success of its models. As of September 30, 2019, seven Section 1115A model[9] tests, [Pioneer Accountable Care Organization (ACO), Diabetes Prevention Program (DPP), Comprehensive Care for Joint Replacement (CJR), Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT), Maryland All-Payer, Accountable Care Organization Investment Model (AIM), and Financial Alignment Initiative for Medicare-Medicaid Enrollees (FAI)], met this goal, according to data received to date. For both the Pioneer ACO and DPP models, the CMS Office of the Actuary (OACT) certified that they produced measurably positive improvements in quality and/or reductions in net program spending such that they could be expanded under Section 1115A of the Social Security Act. The CJR model continues to

[9] For Section 1115A models please refer to: https://innovation.cms.gov

demonstrate reductions in Medicare payments, while maintaining quality of care. During the first two performance years (2016-2017), the CJR model evaluation showed decrease average episode payments of $997 (3.7 percent) for Lower Extremity Joint Replacement (LEJR) episodes. This represents a $146 million gross savings. The RSNAT first interim evaluation showed average quarterly per beneficiary spending on Medicare ambulance services for beneficiaries with end-stage renal disease (ESRD) declining by $523 (72 percent). Average quarterly spending on total Medicare Part A and B services for this group declined by $530, or almost 4 percent. For the Maryland All-Payer model, evaluation data showed a $975 million decrease in total cost of care savings over the first 4 ½ years of the model, amounting to almost a 3 percent reduction in Medicare spending. For the Accountable Care Organization Investment Model (AIM), evaluation data found net Medicare savings of $108.4 million (2.3 percent) in performance year one and $153.4 million (3.0 percent) in performance year two after accounting for earned shared savings paid by CMS to the ACOs. For the Financial Alignment Initiative (FAI), the Health Homes Managed Fee-for-Service Model in Washington State [10]showed decreases in Medicare spending of $202.49 per beneficiary per month (11 percent) over the first three performance years. These data translate to nearly $149.6 million in total Medicare savings.

For other 1115A models, CMS continues to assemble and assess the evidence as it becomes available. Note that results can fluctuate based on new and updated evaluation results and policy decisions. CMS targets are intended to increase the number of models indicating positive results to eight in FY 2020 and FY 2021, consistent with the evidence available to date. The CMS target is flat from FY 2020 to FY 2021 because there are expected to be few evaluation results in FY 2021. This is a result of the pause in new model launches during 2017, as well as the change in evaluation practices during that same period to no longer issue first year evaluation reports.

[10] For more information on models refer to: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalReport3.pdf

CMMI3: Accelerate the Spread of Successful Practices and Models

Measure	FY	Target	Result
CMMI3.1: Percentage of Medicare beneficiaries impacted by Innovation Center models Baseline: 2014 5%	2021	Contextual Indicator	November 30, 2021
	2020	Contextual Indicator	November 30, 2020
	2019	Contextual Indicator	15%
	2018	Contextual Indicator	17%
	2017	Contextual Indicator	13%
	2016	Contextual Indicator	9%
	2015	Contextual Indicator	9%
CMMI3.2: Number of states developing and implementing a health system transformation and payment reform plan Baseline: 2014 25%	2021	13	November 30, 2021
	2020	7	November 30, 2020
	2019	15	14 (Target Not Met)
	2018	16	16 (Target Met)
	2017	17	20 (Target Exceeded)
	2016	38	38 (Target Met)
	2015	38	38 (Target Met)

Measure	FY	Target	Result
CMMI3.3: Number of providers participating in Innovation Center models Baseline: 2014 < 60,000	2021	Contextual Indicator	November 30, 2021
	2020	Contextual Indicator	November 30, 2020
	2019	Contextual Indicator	261,767
	2018	Contextual Indicator	574,467
	2017	Contextual Indicator	219,719
	2016	Contextual Indicator	103,291
	2015	Contextual Indicator	61,000
CMMI3.4: Increase the percentage of active model participants who are highly engaged in Innovation Center or related learning activities Baseline: 2014 56%	2018	Discontinued	N/A
	2017	59.7%	47.6% (Target Not Met)
	2016	64.5%	56.9% (Target Not Met)
	2015	61.0%	58.6% (Target Not Met)
CMMI3.5: Percentage of Model awardees participating in learning activities Baseline: 2018 61%	2021	50%	November 30, 2022
	2020	50%	November 30, 2021
	2019	50%	November 30, 2020
	2018	Baseline	61%

CMS' Center for Medicare and Medicaid Innovation (CMMI) aims to test innovative payment and service delivery models to reduce program expenditures, while improving health outcomes and quality of healthcare delivery to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. Every CMS test of a new service delivery or payment model also includes a plan of action to ensure that the lessons learned and promising practices identified during the test can be spread as widely and effectively as possible to support improvement for both CMS and the health care system at large. CMS strives to understand the level of participation and engagement from beneficiaries, providers, states, payers, and other stakeholders to effectively design, test, and evaluate its portfolio of models.

To date, CMS has introduced a wide range of Medicare initiatives – involving a broad array of Medicare Fee-for-Service (FFS) beneficiaries, health care providers, states, payers, and other stakeholders. In FY 2014, nearly 2.7 million Medicare FFS beneficiaries were impacted by CMS model tests compared to FY 2019, where more than 6.8 million Medicare

FFS beneficiaries participated in CMS models. As a contextual indicator, CMMI3.1 provides a snapshot of the impact on the Medicare beneficiary population of CMMI's models at a given point in time (not cumulative impact), for models that have been operational for more than 6 months. The FY 2019 result of 15% was a decrease compared to FY 2018 due to the ending of the ACO Investment Model (AIM) and the State Innovation Models (SIM) Round Two, both of which impacted large numbers of beneficiaries.

States play a critical role in determining the effectiveness of the health care system and the health of their populations. In addition to being health care payers for Medicaid, CHIP, and state employee populations, states affect the delivery of care through several different levers, including legislation, policy development and implementation, educational institutions, public health activities, and convening ability. From 2014 to 2017, CMS provided funding and technical assistance to states to test states' ability to utilize these levers in the design or testing of new payment and service delivery models that have the potential to reduce health care costs and increase the quality of care delivery in Medicare, Medicaid, CHIP, in collaboration with commercial healthcare systems. In FY 2014, 25 participating SIM states designed or implemented a health system transformation and multi-payer payment reform strategy. In FY 2015, CMS reported an additional 9 states, 3 territories, and the District of Columbia (38 in total), were committed to designing or testing new SIM payment and service delivery models in exchange for financial and technical support. By FY 2016, these 38 states continued designing and testing new payment and service delivery models. In FY 2017, the state count was 20, which included three All-Payer models with formal Medicare Alternative Payment Models (APM) participation, and 17 SIM states that continued testing and improving their health system transformation and payment reform plans. CMS saw a reduction in the number of SIM states in FY 2017, due to the design award project period ending, as intended by the program. In FY 2018, the CMMI3.2 target of 16 states, which included the All-Payer models, was met. In FY 2019, CMS continued model implementation in 11 SIM and 3 All-Payer states. CMS's strategic shift away from custom state models to a focus on new models that could be implemented more uniformly, across multiple states resulted in no new states being targeted for implementation in FY 2020. Rather, the four existing SIM states, 1 Multi-Payer state, and two All-Payer states will comprise our seven total target for FY 2020.

To accelerate the development and testing of new payment and service delivery models, CMS recognizes that many robust ideas will come from a broad array of health care providers, states, payers, and other stakeholders in communities across the country. CMMI3.3 seeks to understand the level of interest and participation among providers in CMS' model portfolio. CMS estimated that the number of participating providers in its payment and service delivery models was more than 60,000 in FY 2014, approximately 61,000 in FY 2015, 103,291 in FY 2016, 219,719 in FY 2017, 574,467 in FY 2018, and 261,767 in FY 2019. The decrease in FY 2019 was largely again due to the AIM and SIM Round 2 models ending.

CMS has created collaborative learning systems for providers and other model participants in order to promote the broad and rapid dissemination of lessons learned and promising practices to deliver better health outcomes, higher quality and lower cost of care for Medicare, Medicaid, and CHIP beneficiaries. Most new service delivery or payment models include a plan of action to ensure that the lessons learned and promising practices

identified during the test can be spread as widely and effectively as possible. In FY 2014, 56 percent of 609 participating organizations in three mature models engaged in learning activities, including Pioneer Accountable Care Organizations (Pioneer ACO), the Comprehensive Primary Care (CPC) initiative, and Health Care Innovation Awards Round 1 (HCIA1), as measured by CMMI3.4.

By FY 2017, 47.6 percent of model participants were participating in learning systems through eight models, including the ACO Investment Model (AIM), the Comprehensive End-stage Renal Disease (ESRD) Care Initiative (CEC), Next Generation ACO, the Bundled Payments for Care Improvement (BPCI) Models, the Comprehensive Care for Joint Replacement (CJR) Model, HCIA2, the Oncology Care Model (OCM), and the Strong Start Model. These models were included because they had been operational for more than 6 months as of September 30, 2016, were currently receiving learning system support, and had learning system data to report. Pioneer ACO and CPC were dropped when their testing periods ended. Embedded within CMMI3.4 reported totals are a wide range of learning events, including: all awardee events, regional webinars, action groups, affinity groups, in-person learning events, and office hours.

While the methodology for calculating the FY 2017 result stayed the same, one reporting change was made in 2017. For multiple model events, the FY 2017 report captures the hosting model (the model leading the event) participant attendance only. Non-host model attendees tend not to show up as predictably as host model attendees do and for this reason, targets and attendee counts for non-host model participants were not included in the count for multiple model events in 2017.

The 2017 participation rate of 47.6 percent fell short of the 59.7 percent target. CMS has analyzed this difference -- refining the approach and improved focus of learning events in response. As learning systems have matured, CMS has learned the importance of providing more tailored learning event options, which better support model participants' wide range of needs. The result is a slightly lower participation rate for each event. In addition, CMS determined that the target for some of the learning events included participants for whom the event was not intended. For this reason, CMS improved the calculation methodology in a new measure (CMMI3.5) effective FY 2018. For measure CMMI3.5, CMS is reporting the FY 2018 baseline of 61 percent. As we move into future model support, CMS continues to optimize measurement of the content and delivery of learning events, to deliver information to support innovation using participant-centered, evidenced-based methodologies designed to optimize adult learning.

CMS DISCONTINUED PERFORMANCE MEASURES

Program Operations Discontinued Measures

MCR30: Shift Medicare Health Care Payments from Volume to Value

Health care costs consume a significant amount of the nation's resources. In the United States, one source of inefficiency is a payment system that rewards medical inputs rather than outcomes, has high administrative costs, and lacks focus on disease prevention.

This measure focused on increasing the percent of Medicare FFS payments that were tied to innovative payment and service delivery models. These innovative payment models can reduce program expenditures, while improving or preserving beneficiary health and quality of care. These alternative payment models (APMs) create new incentives for clinicians to deliver better care at a lower cost. While CMS made progress in 2018, it fell short of its target of 50 percent.

To reflect Administration priorities and focus, CMS discontinued the MCR30 goal after 2018, and developed a new goal (MCR36), measuring the increase in the percentage of Medicare health care dollars linked to APMs that requirerequire participants to take on downside risk (see MCR36: Increase the percentage of Medicare health care dollars tied to Alternate Payment Models (APMs) incorporating downside risk).

Measures	CY	Target	Result Available
MCR30.1: Increase the percentage of Medicare Fee-for-Service (FFS) Payments tied to Alternative Payment Models Baseline: Calendar Year (CY) 2014: 22%	2019	Discontinued	N/A
	2018	50%	41% (Target Not Met)
	2017	40%	38% (Target Not Met)
	2016	30%	31% (Target Met)
	2015	26%	26% (Target Met)

MCR31: Improve Patient and Family Engagement by Improving Shared Decision-Making

This goal focused on assessing an important component of patient experience of care with their provider. Shared decision making between patient, caregiver and provider is considered to be a fundamental component of a patient-centered healthcare system that leads to improved health outcomes for patients. CMS measures shared decision making through the Shared Decision Making Summary Survey Measure (SSM), which is collected and reported through the Clinician and Group- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for the Merit-based Incentive Payment System (MIPS) beginning in 2017 and the CAHPS for Accountable Care Organizations (ACOs) Survey administered by participating in the Medicare Shared Savings Program (Shared Savings Program). This SSM was previously reported in the Physician Quality Reporting System (PQRS) program, which sunset in 2016.

CMS planned to re-establish the baseline for this goal (based on the results from the new survey for CY 2018), which was expected to be available to CMS in July 2019, however due to recent and anticipated future changes to the CAHPS survey questions and lack of stable data, CMS discontinued reporting this goal as of FY 2018.

Measure	CY	Target	Result
MCR31: Improve Clinician and Group- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Shared Decision Making Survey Score Baseline: CY 2014: Medicare Shared Savings Program (MSSP) ACO CAHPS: 74.6% *ACOs Mean Score	2019	Discontinued	N/A
	2018	Establish new baseline Developmental (Baseline)	Baseline not established*
	2017	76%	75.85% (Target Not Met)
	2016	Historical Actual	75.40%
	2015	Historical Actual	75.17%*

* A new baseline cannot be established due to the lack of available, stable and trend data resulting from the recent CAHPS survey update.

MCR35: Reduce the Risk of Vascular Access-Related Infections by Reducing the Rate of Long-Term Central Venous Catheter (CVC) Use Among Prevalent Patients Nationally with the Placement of an Arteriovenous Fistula (AVF) or Graft

The purpose of this measure was to encourage and support the safest hemodialysis, to reduce harm in dialyzing patients, and to reduce costs associated with infections. Individuals are diagnosed with End Stage Renal Disease (ESRD) when their kidneys are no longer able to remove excess fluids and toxins from their blood. CMS set a national goal of reducing the rate of patients dialyzing with long term catheter (LTC) of greater than 90 days, to less than 10 percent. As a result of the ongoing work of the ESRD Network Program and efforts within the dialysis community, in 2017 the national level of dialyzing patients with an arteriovenous fistula (AVF) placement is approximately 63-68 percent. CMS continues to promote the placement of AVFs and arteriovenous grafts (AVGs) through quality improvement of the ESRD Networks, reducing the use of long term catheters (LTCs).

CMS is discontinuing MCR35 goal as of FY2018 to focus on Increasing Patient Choice in Dialysis Care (MCR37) in this critical population. This new goal (MCR37) reinforces the President's Executive Order (EO) on Advancing American Kidney Health (AAKH) and the FY 2020-2021 HHS Agency Priority Goal (APG) on Kidney Care, emphasizing patient choice for home modalities. MCR37 will track our progress toward this goal.

Measure	FY	Target	Result
MCR35: Decrease the rate of long-term central venous catheter (CVC) use among prevalent patients, by increasing the patients that are no longer dialyzing with a long term catheter for greater than 120 days*	2018	Discontinued	N/A
	2017	Baseline	29.4%

***** Prevalent patients are those on renal replacement therapy, excluding patients with acute renal failure, those with chronic renal failure who die before receiving treatment for ESRD, and those whose ESRD treatments are not reported to CMS.

Medicaid Discontinued Measures

MCD10: Improve Access for People with Disabilities and Older Adults, by Increasing the Proportion of Public Funding Directed to Home and Community-Based Services (HCBS) as a Portion of Long Term Services and Supports (LTSS) Expenditures

Home and community-based services (HCBS) are more cost-effective than institutional care for many beneficiaries (https://www.medicaid.gov/medicaid/ltss/downloads/moneyfollows-the-person/mfp-2015-annual-report.pdf). Several statutory programs, in addition to §1915(c) HCBS waiver programs, provide options for people to receive long-term services and supports in the community. These include the Community First Choice state plan option, flexibilities in §1915(i) state plan HCBS, the extension of and improvements to the Money Follows the Person (MFP) Rebalancing Demonstration, and an extension of spousal impoverishment protections to people who receive HCBS.

CMS is discontinuing these measures which are reaching their end dates in 2020; however, CMS is exploring the development of new measures to reflect future progress related to Long Term Services and Supports (LTSS) rebalancing, which refers to the extent to which LTSS spending and use are for services delivered in home and community-based settings rather than institutional settings. CMS will continue to report on these goals through 2022. Further, data associated with these goals have been incorporated into CMS's Medicaid and Children's Health Insurance Program (CHIP) Scorecard: Percentage of Long-Term Services and Supports Expenditures on Home & Community Based Services by State. The Scorecard serves to increase public transparency and accountability about the Medicaid programs' administration and outcomes. Information in the Scorecard spans all life stages covered by Medicaid and CHIP. The Scorecard includes information on selected health and program indicators. It also describes the Medicaid and CHIP programs and how they operate. (See https://www.medicaid.gov/state-overviews/scorecard/ltss-expenditures-on-hcbs/index.html) CMS plans to establish a new GPRA measure before final reporting of the current measures ends. Federal and state Medicaid policies have had a major impact on shifting service modalities for people who need LTSS away from institutional services and toward community-based services. These policies have not only increased the quality of life for people with LTSS needs, but they also have been successful in using limited Medicaid resources more effectively[11] [12].

[11] https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html

[12] https://www.medicaid.gov/sites/default/files/2019-12/ltss-toptenreport.pdf

Measure	FY	Target	Result
MCD10.1: Increase the percentage of Medicaid spending on long-term services and supports for home and community based services (HCBS) to 65 percent by 2020. Actual-Baseline: 49.50% (FY 2012)	2021	Discontinued	Discontinued
	2020	65%	April 30, 2022
	2019	63%	April 30, 2021
	2018	61%	April 30, 2020
	2017	59%	58% (Target Not Met)
	2016	57%	57% (Target Met)
	2015	55%	55% (Target Met)
	2014	53%	53% (Target Met)
	2013	51%	51% (Target Met)

Measure	FY	Target	Result
MCD10.2: Increase the Number of States that Utilize at least 50 percent of Medicaid Spending on Long-Term Services and Supports for Home and Community Based Services (HCBS) by 2020.* Actual Baseline is 47.1%* or 23 States and District of Columbia (FY 2012)	2021	Discontinued	Discontinued
	2020	38 States and District of Columbia (76.5%)*	April 30, 2022
	2019	37 States and District of Columbia (74.5%)*	April 30, 2021
	2018	36 States and District of Columbia (72.5%)*	April 30, 2020
	2017	35 States and District of Columbia (70.6%)*	28 States and District of Columbia 56.9% (Target Not Met)
	2016	38 States and District of Columbia (76.5%)*	30 States and District of Columbia 60.8% (Target Not Met)
	2015	35 States and District of Columbia (70.6%)*	28 States and District of Columbia 56.9%* (Target Not Met)
	2014	31 States and District of Columbia (62.7%)*	25 States and District of Columbia 51.0%* (Target Not Met)
	2013	27 States and District of Columbia (54.9%)*	25 States and District of Columbia 51.0%*

* The target and result percentages for MCD10.2 have been corrected from previous versions appearing in past versions of the CMS budget.

Medicare Quality Improvement Organizations Discontinued Measures

QIO9: Improve Health Outcomes for Medicare Beneficiaries by Providing Technical Assistance (TA) Support Related to Value-Based Payment and Quality Improvement Programs to the Eligible Clinician Population Working in Ambulatory Care Settings

The purpose of this measure was to ensure broad-reaching national access to technical assistance (TA) for clinicians in clinical practices, in order to support successful participation in value-based payment and quality improvement programs. Programs provided TA through Learning and Action Network (LAN) events and/or direct TA. These LAN events included topics related to improving health outcomes for beneficiaries and improving care coordination and costs, related to care. Measuring the reach of TA across programs ensured these programs achieved successful outcomes. CMS Administrator Seema Verma publicly communicated the successful results in a May 2018 blog post**:** https://blog.cms.gov/2018/05/31/quality-payment-program- exceeds-year-1-participation-goal/. CMS will discontinue reporting on this goal as of FY 2020.

Measure	FY	Target	Result
QIO9: Increase Clinician Practice Technical Support	2020	Discontinued	N/A
	2019	90%	April 30, 2020
	2018	*540,000 (90% of 600,000 eligible clinicians)	39.51% (Target Not Met)
	2017	*510,000 (85% of 600,000 eligible clinicians)	77% (Target Not Met)

* The FY 2017 and FY 2018 actual and confirmed data, for FY 2017, using the validated denominator (eligible clinician count), was 511,590 and 254,635 respectively. The FY 2018 target of 540,000 was not met as the denominator is less than half of the target. Using the target denominator number for FY 2018 and the validated numerator FY18 data of 237,086 resulted in 39.51%, target not met in FY 2018.